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ABSTRACT

This manual offers practical guidelines for many of the concerns that parents have about their infants and toddlers. The manual is divided into seven chapters; each is written by an expert in the field of pediatrics, early childhood education, nutrition, or family care. The following areas are covered: (1) newborn and infant care; (2) growth and development from birth to age three; (3) nutrition for infants and toddlers; (4) medical and dental care; (5) minor illnesses and injuries; (6) minor hospitalizations; and (7) discipline. Following each chapter is a bibliography of resources. Eight appendices offer information on sterilization of bottles and nipples, daily guide to good eating, preparation of evaporated milk/formula, recipes for play dough and finger painting, finger plays and songs, child development record book for parents, books for parents and babies, and medication and medical equipment for the home. A sample health record log concludes this manual. (EM)

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# A PARENTS' GUIDE FOR WELL-BABY CARE AND MINOR HOSPITALIZATIONS

Alice Luchini, R.N.
Editor

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This book is dedicated to

Our Husbands

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Alice Luchini, R.N.
Editor

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# INTRODUCTION

Parenthood brings with it an assortment of new joys and surprises, new responsibilities, and new roles for the parent to fill, such as teacher and as child psychologist. Parents need to discover and appreciate the pleasures that come from watching their child grow and develop day by day. It is important for parents to communicate this appreciation to their children, whether done by a kiss or a hug, or by telling them how much you love them. It is also important to remember these positive emotions for yourself, so that you may have them to draw upon during those times when the work of parenthood seems to outweigh the pleasure.

Becoming a parent does not automatically give us the information and wisdom that is needed to successfully rear a child. Modern patterns of living may mean that new parents are separated from their own families by thousands of miles, and, thereby, may find it difficult to obtain the support that their own parents might have given them. Smaller family size may mean that fewer people have learned infant and child care first-hand in their own families while they were growing up. Since new parents cannot rely solely on a combination of common sense and instinct to guide them, other sources of information, such as books and parenting classes are indispensable. This manual offers practical guidelines for many of the questions that parents have about their infants and toddlers. Having such readily available information can contribute to confident and successful child-rearing in a more relaxed home atmosphere.

J. Stephen Schechter, M.D.

# 1

# INFANT CARE

Brenda M. Zoltak, R.N., M.S.N., P.N.P.

Brenda M. Zoltak is currently a pediatric nurse practitioner in a high risk follow-up clinic at James Whitcomb Riley Hospital for Children, Indiana University, Indianapolis, Indiana. As a pediatric nurse, she has been employed in a variety of settings, including a surgical unit, a pediatric intensive care unit, a pediatric burn unit, and a pediatric out-patient/emergency department. She has also been a faculty assistant at the University of Wisconsin-Milwaukee School of Nursing and an instructor of Family Nursing at Deaconess Hospital's School of Nursing, Milwaukee, Wisconsin. She received her B.S.N. from the University of Wisconsin-Milwaukee and M.S.N. and P.N.P. from the University of Colorado Health Sciences Center, Denver, Colorado. Her current interests are in promoting automobile safety for infants and children and in infant stimulation programs for hospitalized infants.

A focus on how to keep your infant healthy is important in the first months of caring for your infant. Concerns that parents often have include: physical appearance, feeding techniques, bathing, body functions, clothing, and safety. Difficulties parents experience that are not discussed in this section should be mentioned to the infant's physician or the Well Baby Clinic in the community.

General appearance. When the infant is first born the skin is red, smooth, and puffy. The baby may have a white, sticky substance (vernix caseosa) covering the skin. This will soon disappear. Baby's head appears large in comparison to the rest of the body. The head may have an unusual shape at birth, but it will become rounder within a few days. The baby does not have good head control, so support the neck when holding the baby. The infant will hold the arms and legs in a flexed position and will move them in large general movements.

The infant can open the eyes and can see. The baby will focus on mother and father and will follow faces a short distance. Parents can facilitate this focusing by holding the infant in a crooked arm, looking into the baby's face and speaking to the infant. The baby is able to hear. The infant will startle with loud noises.

As the infant grows, strength develops from head to foot. This means the infant will develop head control before learning to sit. Sitting occurs before crawling, and crawling occurs before walking.

The infant's hands are clenched the first month of life. After this time they are open more often, and the infant can bring both hands to the middle of the body. Around three to four

months of age the infant will be able to hold onto objects and will reach out for them. By seven to ten months the baby has more control over the hands and fingers and is able to pick up very small objects easily.

The young infant will vocalize by crying and cooing. Around two to four months of age infants begin to laugh and squeal. Although the infant will not imitate speech sounds or "talk" until six to ten months, it is best to speak to the infant as if there is understanding. Babies do understand speech long before they begin to speak.

Each baby develops an individual and unique personality. No two infants are exactly alike. This is one of the challenges of parenthood.

Bottle Feeding. Feeding time should be a quiet time for mother (or father) and the baby. When being fed, the baby should be held in a semi-upright position. Make sure the formula is always in the nipple. It is best never to prop the bottle -- the formula may come too fast for the baby to handle. Propping the bottle also contributes to middle ear infections and dental caries (cavities). Even when the infant is older and able to hold the bottle, it should be drunk in a sitting position.

Breast Feeding. If breast feeding the infant, ask the nurse in the hospital for assistance. Breast feeding is a natural way to feed the baby, and the nurse will be able to give some feeding tips. There are also organizations that are helpful in supporting mothers who breast feed.

During your pregnancy the breasts have been enlarging. Now, after the baby is born, they will begin to produce milk. Milk production usually begins the third or fourth day after delivery. Allowing the infant to nurse the breasts will aid in the milk production. If the infant is healthy, there is no need to supplement with formula before the breast milk comes in.

There are requirements for breast feeding. The first is for mother to have a comfortable bra that gives good support. The second is for mother to increase her fluid, protein, and calorie intake. The third requirement is to be in a relaxed environment; this allows for milk "let down" to occur.

For the first breast feeding, sit in a comfortable position with the arm holding the infant well supported. This first time allow the infant to suck for five minutes on each breast. Help the baby latch onto the breast by touching the baby's cheek near the mouth with the nipple. The infant has a rooting reflex--the infant will turn toward the touch on the cheek. Touch the infant with the nipple, rather than the fingers, so the infant turns toward the breast. The infant sucks by gently squeezing the breast between the tongue and upper roof of the mouth. The baby needs to put the nipple and the areolar tissue (brown area around the nipple) into the mouth for an efficient suck. If the baby sucks only on the nipple it may become sore. The areolar tissue secretes a liquid which helps protect the nipple.

When the infant has nursed for five minutes, mother should slide her finger into the mouth to break the seal. Touch the infant's cheek with the other breast to stimulate the rooting reflex so the infant latches onto the other breast. If the infant's nose is pressing into the breast and is occluding the nasal airway, mother should gently press on her breast with her hand to give breathing room.

As a mother grows accustomed to the infant's sucking, she should gradually increase the time she allows the infant to nurse. A gradual increase prevents the nipples from becoming sore.

Infants vary in how often they will suck, but by the third or fourth day, when the milk production has begun, the infant will need to feed every three to four hours. By this time the length of time the infant is allowed to suck will be 10 - 15 minutes. The milk production is

stimulated by the amount the infant drinks and by completely emptying the breast. The more milk the infant needs, the more mother will produce. Mother can completely empty her breasts by alternating which breast she offers first. Offer the right breast first for the initial feeding; the left breast first for the second feeding; then, the right breast first for the third feeding.

Breast milk looks thinner than cow's milk or formula, but it is rich in the nutrients the baby needs. To increase the amount of milk the baby receives, nurse more frequently.

Nipple Care. To keep nipples soft, apply a lanolin lotion or A&D ointment to them between feedings. Be sure to wash it off before the feeding. Slipping a nursing pad or some cotton into the nursing bra will help absorb any leaking milk that may occur between feedings.

Engorgement. When a mother has been breast feeding her infant routinely, she may develop engorgement--fullness of the breasts. The way to relieve engorgement is to nurse the infant. Occassionally the breast may be so full that the infant is unable to grasp the nipple and areolar tissue. When this happens mother may need to manually express some milk.

Manual Expression. To manually express milk, cup one hand around the breast, with the fingers below and the thumb above, gently bring forefinger and thumb forward and together towards the areolar tissue. This compresses the glands and causes the milk to flow. Express as much milk as needed to allow the infant to nurse.

There may be times when a mother is unable to breast feed. At these times when the breasts become full they need to be emptied completely. Use a breast pump or manually express milk. To be sure the breasts are completely emptied with manual expression, work in a circular motion around the entire breast to relieve all the milk ducts. Breast pumps can be bought or rented from

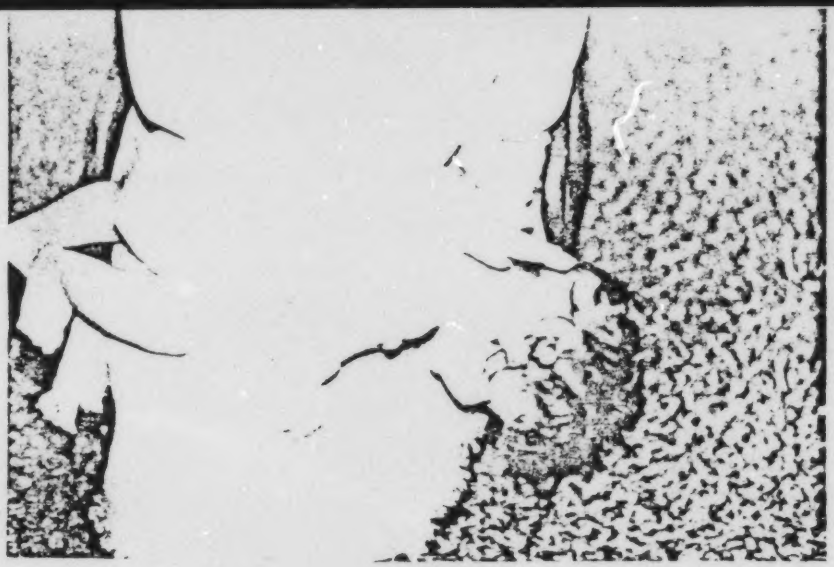
pharmacies. There are several types available. Manual breast pumps are fine for occasional use, but if milk production is to be maintained over a period of several weeks, without the infant, an electric pump is best.

Bottle Feeding The Breast Fed Infant. Occasionally, a bottle is more convenient to use than the breast. A bottle of previously expressed breast milk or formula can be used. If the infant has received a bottle intermittently within the first two months of life, it is usually well accepted. Some couples routinely plan for the infant to receive one bottle feeding a day. This allows father to participate in feeding the baby early in life.

Feeding time should be an enjoyable time for parents and the infant. The infant needs both food and human contact with both parents for optimal growth and development.

Weaning. Weaning can be accomplished at any age that is convenient for mother and infant. Because nursing stimulates milk production, a decrease in nursing reduces the amount of milk produced. Weaning occurs by slowly decreasing the number of breast feedings and replacing the breast feedings with a bottle. Try discontinuing the midmorning or midafternoon nursing first. After two or three days, discontinue another breast feeding supplementing with a bottle. Curtail the next feeding when mother and infant are ready to do so. Continue to eliminate breast feedings one at a time. If the infant is old enough to use a cup instead of a bottle, replace the discontinued breast feedings with cup feedings.

Bubbling. Whether breast or bottle fed, the infant needs to be bubbled (burped) to decrease the air in the stomach. To do so, gently compress the infant's abdomen by leaning baby forward on one hand while gently rubbing or patting the back with the other hand. Bubbling is also accomplished by laying the infant on the shoulder or face down on the lap while rubbing the back.



Infants differ in the amounts of formula they can consume before they need to be bubbled. If the infant has colic or passes a large amount of flatus (gas) routinely, it may be beneficial to bubble the baby before the feeding. Babies need to be bubbled after one to two ounces of formula or after sucking the breast for five to ten munites. Be sure to have a diaper or cloth ready because burps are generally "wet."

Sucking. Babies have a need to suck, just as they have a need to sleep. Babies require about two hours of sucking a day. If the infant consumes the formula quickly, the infant may enjoy sucking on a pacifier. Excessive sucking should be discussed with your pediatrician.

Hiccoughs. Occasionally, babies develop hiccoughs. To stop them, feed the baby a little water or formula. Hiccoughs may be more alarming to the parent than to the infant.

## Bathing

Most hospitals incorporate some teaching classes into the mother's post partum (after birth) stay. Try to attend these sessions. Once home with the infant, giving a bath may seem like a tremendous chore.

Sponge Bath. The first step is to assemble what is needed. For a sponge bath: basin, soap, washcloth, dry towel, and a flat area on which to lay the baby are required. Any flat area will do --mother's lap, a bed, or a table padded with a towel. Prepare the water next; it should feel warm, but not hot. If using a thermometer, it should read between 99° and 100°F.

During the bath, support the baby's neck and back in a semi-upright position with one forearm and hand leaving the other hand free to cleanse the baby. Always wash and dry one area of the baby before progressing to the next area. Start with clear water and wipe out the eyes one at a time, beginning with the corner near the nose and wiping towards the outer corner. Use a different part of the washcloth for each eye. Pat the lids gently dry with the towel. Next, wash the baby's ears with the cloth. Wash only what you see. It is not necessary to clean out the ear canals. Ears are cleansed naturally with the production of wax. It is not necessary to remove the wax with a cotten tipped swab. Do remember to wash behind baby's ears and to dry this area thoroughly. Continue to clean the rest of the baby's face with clear water and pat it gently dry. Sometimes babies' noses have a bit of dried mucus in the nares (holes), and it may be necessary to soften these crusts with water for a few minutes before attempting to remove them.

For the rest of baby's body, use a baby soap either rubbed onto your hand or onto a washcloth to make a lather. Baby's neck, with all its creases, becomes easy to wash and dry by allowing the head to drop back a little while still supporting it. The baby can continue now to be supported by the forearm and hand, but it may be convenient to lay baby on the back as arms, hands, chest, abdomen, legs, and feet are washed. Straighten the arms, fingers, and legs to get the creases clean and dry. Turn baby on the abdomen or sit baby up to wash and dry the back. The genitals are washed next with baby again on the

back. A baby girl is always washed from front to back to prevent any bacteria or stool from spreading from the rectum into the urinary tract or vagina. Her labia (lips) should be separated as they are washed. Wash off the cheesy, white material (smega) that accumulates. If baby is a boy, his penis and scrotum need to be washed. If he is not circumcised, gently retract the foreskin and cleanse the glans (head) of his penis. As the infant boy matures, the foreskin will gradually pull back further. Sometimes a boy who has been circumcised has a small amount of foreskin remaining. Cleanse his penis in the same manner as an uncircumcised penis. In other boys who have been circumcised, no special care is needed; just cleanse as you did the rest of his body. The buttocks and anus of either sex child are always washed last.

Some newborns fuss with their baths, others do not. The baby usually fusses as a reaction to being exposed, so only exposing one area of the body at a time may help alleviate the fussiness. Wrap baby's body with a towel or blanket while washing the face. Wrap the lower body while washing the upper body, and the upper body while washing the lower body. Holding baby close or holding the baby's arms across the chest may also help create security to quiet baby.

Tub Bath. To give baby a tub bath, assemble the same articles needed to give a sponge bath--soap, washcloth, dry towel, and a flat area on which to dry the baby. A tub big enough to hold the baby in a sitting position is also needed. The tub can be the kitchen sink, a plastic wash basin, or a baby tub. The bathroom tub can be used, but other tubs are easier to use and require less water. A few inches of water is all that is needed in any of the tubs.

Follow the guidelines outlined for a sponge bath, being sure to always support the baby. Wash the face without soap, proceed to wash the rest of the body with soap, and finish with the buttocks and anus.

Tub baths can be fun, especially for the older infant. Allow the baby to splash and play with toys. Remember though, older infants do need to be observed constantly while they are bathing.

Occasionally between 9 months and 2 years, the infant develops an unfounded fear of tubs. The infant may need to be sponge bathed during this period, or may be allowed to take a tub bath with a parent. Fortunately, this fear will be outgrown.

Bathing Tips. One may wish to give baby a daily bath, usually at a set time. However, it is not necessary to give a bath every day, but do be sure the mouth area is cleansed after every feeding and the diaper area is cleaned with every change.

Babies can be bathed before or after a meal. However, if bathing the baby causes crying, the baby may regurgitate if bathed immediately after a feeding. If the infant enjoys the bath, it is fine to give it after feeding.

Baby powders and oils are not necessary. If used, use small amounts. The parent should put the powder in the hand before putting it on the baby. This prevents baby from breathing in the small powder particles.

Baby's fingernails and toenails grow rapidly and can be clipped straight across as needed to keep baby from scratching. Clipping is accomplished more easily when the baby is asleep.

Shampoo. Shampoo the baby's hair during the bath after washing and drying the baby's face. Rub a little soap into your hand and use a little water to create a lather on the baby's head. Soap is used on the baby's scalp for the first weeks of life, then a baby shampoo is used. Baby shampoo is preferred over regular shampoo because it is not as irritating to the eyes if some shampoo accidently runs into them. Scrup the baby's entire head gently. Do not be afraid to rub the baby's soft spot (fontanel). The fontanel is covered with a thick membrane of skin and will not be damaged with ordinary scrubbing. Rinse the baby's head with water cupped in the hand. Allow the baby's head to drop back a little as it is rinsed so the water does not run down the face. Dry the head and hair thoroughly. The baby does not need a daily shampoo; once a week is usually enough.

Cradle Cap. Many babies develop cradle cap. Cradle cap is due to the build up of natural oils on the scalp. Generally, it develops first over the soft spot and then spreads. It usually occurs because parents are afraid of damaging the soft spot and therefore do not scrub well enough. If cradle cap does develop, put a small amount of baby oil over the affected area, allow it to soak in for five minutes, then shampoo the oil out. After drying the hair, comb through it with a fine tooth comb. Continue to apply the oil before each shampoo until the cradle cap has disappeared. Shampoo more often than usual until the scalp is clear.

## Umbilical (Navel) Care

The umbilical cord, which provides nourishment for the fetus in the womb, is cut at birth. The remaining stump will need special care for the first few weeks. The stump takes seven to

ten days to dry and fall off. Wash and dry the stump and surrounding area every day. The doctor may request the area be washed with alcohol about four times a day in order to facilitate the drying process. Keeping diapers below the umbilical area helps to dry the cord and helps avoid irritation caused by the diaper rubbing the area.

After the stump drys and falls off, a moist, raw area will remain for a few days until the area scabs over. Continue to keep the navel clean and dry. The scabbed area will take two to three weeks to heal completely.

Many doctors will ask that baby be given a sponge bath until the umbilical cord stump is healed. Other doctors do not make this distinction.

Call the doctor if the navel has not healed in one month, or if at any time during the healing process the area looks red, is warm and tender to the touch, or if purulent (pus-like), foul smelling drainage occurs.

Umbilical Hernias. Umbilical hernias are caused by weakness in the muscles of the abdomen. They are usually not a cause for concern, since they usually disappear without any treatment. Belly binders or coins taped over the navel will not cure hernias and, therefore, serve no helpful purpose.

Circumcision Care. If the parents have made the decision to circumcise the infant boy, it will probably be done in the nursery before leaving the hospital or in a religious ceremony in the first few weeks after birth. A small piece of gauze dressing with petroleum jelly on it should be applied to the tip of the penis and changed every time the baby urinates. Keep the petroleum jelly on for a few days. There may be a little blood drainage the first two days--this is normal. About the second day a little yellowish-white drainage may be seen; this too is normal and expected as part of the healing process. By the

third day the infant's penis should be healed, and no extra care should be needed after that, except for cleansing with each diaper change.

Stools (Bowel Movements). Baby's first bowel movements are called meconium stools; they are greenish-black and sticky. Meconium stools may occur for three days. By this time the infant has been fed and this changes the characteristics of the stool. For the next few days stools will be greenish-brown to yellowish-brown and loose. The stool will change one more time in the first week of life depending on the type of formula the baby is being fed. If the baby is being

breast fed, stools will be yellow, seedy, or pasty, and may smell sour. If the infant is being bottle fed, the stools are yellow or brown, smelly, and soft. Babies being breast fed may have six to eight stools per day for the first few months, but then their stools gradually firm up and may become as infrequent as one every other day. Initially, babies who are fed formula do not stool as often as breast fed babies. They may stool four to six times a day at first, and as they grow a few months older they stool one to two times a day.

Constipation. Many babies strain or whimper a little when they have a bowel movement. As long as their stool remains soft there is nothing to worry about. Babies seldom become constipated. Constipation is not defined as the number of stools in a day, but rather refers to the characteristics of the stool. Constipated stools are those that are hard and dry.

Undigested Food. When first begun on solid foods and then again when introduced to finger foods, baby may have some undigested food in the stool. This is natural. If, however, the undigested food is found in a loose stool that also has much mucus, give less of the food next time. Remember that these foods are new to the infant's digestive system, and the system may need some time to adjust to the new types and textures of foods.

Diarrhea. Occasionally babies have bouts of diarrhea or loose stools. This will be discussed in the chapter on Minor Illnesses and Injuries.

Crying. Babies cry for a number of reasons. Remember that this is the basic way in which they communicate. Babies have a "hungry cry"; they need to be fed. This cry is loud and demanding. Babies cry when they are uncomfortable and when they are wet, cold, or hot. Infants may also cry when they are tired or when they want attention, e.g., someone to play with them. The parent will learn to distinguish the infant's many cries.

Quieting. Infants are very individual in their responses to attempts to quiet them. Some babies quiet when they are swaddled in their blankets; others quiet by having the parent's hand placed on the stomach. Others quiet with a pacifier, while some infants have to be picked up and rocked or walked.

Fussiness. Babies usually have a fussy period sometime during the day, most frequently in the late afternoon. If the baby is not hungry, wet, cold, or too warm try to ignore this fussy period. If the infant is not attended to, the baby may then go to sleep. If the fussiness continues and becomes loud crying and the infant seems very uncomfortable, attempt to quiet the infant.

Sleeping Habits. Infants differ in the amounts of sleep they need, but as they grow older they need less sleep. The newborn may sleep as much as 12-20 hours a day. By the age of one year the baby is sleeping through the night with two supplemental naps during the day. By the age of two years the child may only need one nap during the day besides the nighttime sleep.

The baby may sleep in a bassinette, cradle, or crib. If there is not a separate room for the infant, keep the baby in the bedroom during the day. But at night it is best if baby is moved out of the room in which parents are sleeping. Keep the baby in the living room if there is no separate bedroom. It is preferable that parents not sleep in the same room as the infant. In the first month of life, babies make many respiratory noises--sneezes, grunts, gasps. These sounds are normal for the baby to make, but the sounds coming from the baby have a tendency to prevent the parents from sleeping and may even awaken them from a sound sleep. If the baby is in the next room, parents can hear the cry that says that baby needs them, but they will not hear all the little, natural sounds that the baby makes.

It is very important not to have the baby sleep with the parents in their bed. There is always the danger of suffocation by a pillow and of accidental injury by falling out of the bed or being rolled on by a parent.

Infants can sleep either on their tummy or back, but, until they begin rolling over, the preferred position is on the abdomen. If they spit up a little while on their abdomen they drool the formula out and do not choke on it. An infant usually turns the head towards the center of the room where there is more action, so prevent one side of the head from becoming flattened by alternately positioning the baby with the head near the foot of the bed, rather than always having the head near the top of the bed.

An infant will develop a sleeping schedule. During the first two months, babies usually wake during the night for a feeding. As they gain weight they are able to take in more formula and this helps lengthen the number of hours they sleep. Help the infant get on a regular day-night schedule by feeding before being put to bed for the night. After the first two months the infant may continue to awaken. If the baby does so, change the soiled diaper and, unless the baby seems to be very hungry, just leave the baby alone. The baby may fuss a little, but will probably doze off for a few more hours. After a few nights the infant will probably not awaken. Even after infants have been sleeping through the night for some time, they may begin to wake at early morning hours again. If the baby seems unduly hungry, feed. The baby may be experiencing a growth spurt. The next night, however, the parent should try feeding the infant more before being put down for the night. Infants who wake to play should be left to play by themselves while the parents go back to sleep.

During the day the baby will be able to sleep through normal household noises, so there is no need to be extremely quiet. Infants need naptimes

that are regularly scheduled. Older infants can be taken with parents on errands and may sleep if it is their regular time to do so.

Diapers. Diapers can be washable or disposable. If using cloth diapers, fold them so the extra cloth is in the area that the baby usually urinates. This is in the front for boys and for girls it depends on whether they are lying on their abdomens or backs. The baby usually urinates 15-20 times a day. This number will decrease as the baby matures. Change the baby at least after every feeding. If the child cries or seems uncomfortable, change more frequently. If diaper rash develops, increase the number of diaper changes.

After use, cloth diapers should be soaked in a soap and water solution in a diaper pail which can be firmly closed. Diapers soiled with stool should be rinsed in the toilet before being put into the soaking solution.

If, with the use of disposable diapers, the parent discovers that the baby has developed a fine, red rash where the diaper covers the body, the baby may be allergic to this brand of diaper. Switch diaper brands. If laundering cloth diapers and noting this rash, consider changing the brand of detergent.

Disposable diapers and a diaper service make life easier, but they are more expensive than maintaining baby's diaper laundry at home.

Clothing. In general, babies should be dressed in a comparable amount of clothing as the parent finds comfortable to wear. There is a tendency to overdress infants. Indoor temperatures should be kept at 68°; the baby should be comfortable in a light sleeper when awake. Add a light blanket when putting the baby to bed. Touch the baby's arms, legs, or neck to assess how warm the baby is. Usually the baby's hands and feet are cooler than the rest of the body. When infants are cold their faces usually lose their natural color.

Dress the infant according to outdoor weather conditions, such as temperature, wind, sun, and moisture. Remember, however that an infant's head is large and more bare than adults'. A great deal of body heat is lost through baby's head. So, in cooler weather, they should wear caps. In the summer babies should be exposed to direct sunlight gradually; that is, only a few minutes each day, so their skin will not burn. If they are going to be out-of-doors for a long period of time, it is best for them to be in a shaded area and to be protected from sunburn by an application of sunscreen. (Buy a sunscreen containing PABA or p-amino benzoic acid for the best protection.

Shoes. Until your child begins to walk, there is no need for shoes. One may try to keep socks or booties on the infant's feet, but infants have a tendency to kick them off.

When beginning to walk around the inside of the home, it is fine for the baby to go barefoot, or at least shoeless. This helps build the muscles in the feet. Until the infant has been walking for about a year there is a fat pad under the arch that makes the baby's foot appear "flat-footed." This fat pad will disappear as the muscles of the feet develop.

For outside purposes and over unprotected surfaces, a pair of shoes is needed for the walking infant. Soft, flexible shoes are the best. The soft sole allows the baby to exercise the muscles in the feet. Sneakers are inexpensive and do the job well. High topped shoes, if preferred, are fine, but certainly not necessary. High topped shoes do stay on the feet better than lower cut shoes. Make sure to take the baby along to the shoe store. Try the shoe for fit with the infant standing. The big toe should be about a half a thumbnail width from the edge of the shoe. Make sure the shoe is wide enough also. Do not buy shoes that are too big. The infant may wear them out before growing into them. Since the baby's feet grow rapidly, check the baby's feet

in the shoes every couple of weeks. Infants also outgrow socks and footed clothing, and these should be checked so that they will not be allowed to restrict foot movements.

Safety. As the infant develops, it is the primary responsibility of the parents to keep their baby safe. The most frequent cause of death in infants is accidents. Rely on common sense to keep the baby safe.

Never leave infants unattended on high places --beds, couches, tables, chairs. They learn to roll over between two to four months and can fall very quickly. Keep all sharp, breakable, and hot objects well out of their reach. Very early babies learn how to pick up small objects and put them in their mouths.

Once the baby has begun to crawl the entire house will need "baby-proofing." In the kitchen this means removing cleaners and detergents from low cupboards and applying locks to the doors so that the infant cannot open them. Keep hot foods and liquids away from the edge of the table. On the stove, make sure pot handles are turned in rather than out. Remove the knobs from the stove if the infant can turn them on easily. Do not let electrical cords hang down; the infant may try to pull on the cord for support.

In the bathroom put all dangerous substances out of reach. This includes medicines, mouthwashes (they contain alcohol), cosmetics, razors, and cleaning substances. Never leave the hot water running if not in the bathroom.

Living rooms and bedrooms, also, need to be "baby-proofed." Electrical receptacles not in use should be covered with caps (available at hardware stores). Remove breakable items. Put ashtrays somewhere so the baby cannot get at the lit cigarettes or extinguished butts. Many household plants, e.g., dieffenbachia, philodendron, English ivy, poinsettia, are toxic and should be kept out of the infant's reach.

When the infant/child begins to play outdoors, remember to "baby-proof" the garage. There are many dangerous chemicals and machines in ordinary garages.

It is wise to keep the telephone numbers of the doctor, hospital, and poison control center available. If the infant accidentally takes in a harmful substance, call one of the listed numbers for help in deciding the next step. The doctor/poison control center will give the parent special instructions. It is best to start initial emergency treatment at home before rushing the child to the hospital, so take the time to call.

Safe Baby Furniture. Safe baby furniture is a requirement in every household with an infant. One of the most important items to buy or borrow is an infant car seat if the baby will be riding in a car. There are several reputable infant car seats on the market. Check with a local department store for a car seat that is appropriate even before mother delivers the baby. Look for a car seat which has been approved by 1981 Federal Motor Vehicle Safety Standard 213 and which has been dynamically tested. Further, be sure to properly install the seat into the car and do so before mother and the baby leave the hospital. Contrary to popular belief, infants are not safe in an adult's arms. Car accidents are the number one cause of preventable death in all ages of children, including newborns. An infant who always rides in a car seat becomes accustomed to doing so, and does not object to the confinement.

Baby carriers are different from infant car seats and should not be used instead of car seats. Inspect for a wide supporting base, a safety strap, and a nonskid bottom.

If buying a crib or just borrowing one, check to see if there is 2 3/8 inches or less between the slats. Two and 3/8 inches is about the width of three adult fingers. Make sure the mattress fits snugly against the frame; there should be less than two finger widths between the mattress and the front and back headboards. Keep the

mattress as deep as possible in the crib. Make certain locks and latches are secure and have no rough edges that could harm the infant.

High chairs should have a wide base and come equipped with a safety strap that should be used. The tray should latch firmly. Infants should not be left unsupervised in high chairs.

Walkers should have a wheel base wider than the seat. Screws should be covered so they will not injure the infant. Remove throw rugs from where the infant will be walking in the walker so there is less chance of the walker tipping. Be sure to guard staircases with gates.

Strollers, too, need a wide wheel base, safety strap, and brakes that lock securely. Make sure there are no sharp edges here either. Latching devices should be able to be securely fastened.

Playpens, like cribs, should have only three finger-breadths between slats, or should have small mesh netting. The playpen should have firm flooring and be lined with a durable foam pad.

Infants, along with their parents, are becoming more mobile. If investing in a front "napsack" type carrier, try the infant in it for size. Make sure it does not restrict the circulation in the infant's legs. Make certain, too, that it snaps securely. There are also infant backpack carriers. These should not be used until the baby is four or five months old and able to support the weight of the head. Try the infant for size, check the material for strength, check for a safety strap, and make certain that there are no sharp joints and that the frame near the baby's head is padded.

It may take extra time to "baby-proof" the home and car and to make the baby secure, but it does prevent accidents, injuries, and deaths.

BIBLIOGRAPHY

American Academy of Pediatrics. News and comment, December 1980, 31(12).

Brazelton, T.B. Infants and mothers. New York: Dell, 1969.

Caplan, F. (Ed.). The first twelve months of life. New York: Grosset & Dunlap, 1973.

Fitzpatrick, E., Reeder, S., & Mastroianni, L., Jr. Maternity nursing (12th ed.). Philadelphia: Lippincott, 1971.

Kempe, H., Silver, H., & O'Brien, D. Pediatric diagnosis and treatment (5th ed.). Los Alton, Ca.: Lange Medical, 1978.

Spock, B. Baby and child care. New York: Pocket Books, 1965.

U.S. Consumer Product Safety Commission. "It Hurts When They Cry." U.S. Government Printing Office: 0-208-826, 1976.

Whaley, L. & Wong, D. Nursing care of infants and children. Mosby, 1979.

# 2

# GROWTH AND DEVELOPMENT

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Following nine months or longer of sharing and planning, baby's arrival is welcomed to the encircling security of parental arms. An old adage states the relationship in these terms, "Nine months in the womb, nine months in the arms." The dependency and vulnerability of the infant is seldom again matched in the human life span. Parents in our society are the coordinators of all aspects of their children's lives. Establishing an environment for healthy development is an exciting adventure for new parents.

Unique Roles of Parents. Historically mothers are thought the most important person in the newborn's world, but this should not be the case. Fathers can and do become involved with their infants. Essentially only one activity is restrictive for fathers, and, of course, that is breast feeding.

Both parents can become deeply engrossed in their opportunities to hold, look at, and talk to their baby for frequent and extended periods of time. Your infant and you -- the parent -- are both benefitted from these early experiences. Note every detail of your baby's uniqueness. Your feelings of self-worth are increased by this positive exercise. In turn, your child's developing self-image is helped as well.

The home is a rich learning environment with the single greatest advantage being its people resources: MOMMY and DADDY. Fathers as well as mothers often need support those first hours and days following baby's birth.

Encouraging each other to look at, hold, and to vocalize to baby is important for baby's mental health. From those first three days develop the individual parenting approaches. Love requires knowledge about each other and is known to be strengthened through interaction with each other and your baby.

Parental Absence. When circumstances prevent the presence of the two biological parents, a substitute role model for the missing parent(s)

should be initiated as early as possible. When one parent must assume both parenting roles, the child's potential is decreased. The effect of the absence is cumulative. A wise single parent (biological or adoptive) plans for the closest consistent substitute of the missing sex for the infant or toddler, i.e., an available relative or friend who could spend six hours or more per week with the infant or toddler.

## The Dependent Infant

One of the great wonders of civilization is that the human infant survives our stumblings and failings as anxious first-time parents. The first-born is subject to a variety of factors: the economic status; the friendship and emotional support of kinship; the health, educational background; and beliefs held by the new parents.

Crying. The presence or absence of adult emotional support is often responsible for the tolerance level of parents during the months of infant crying. Communication with your infant comes from observing those cries and learning which response satisfies his basic needs: feeding, changing, rocking, talking, or playing. Given opportunity, a schedule develops which supports understanding of the message baby was trying to give through crying. Crying is the communication vehicle of the infant. An attempt to comfort baby should be made in five seconds following baby's cries. Meeting the physical needs of your baby also meets his psychological needs.

Changing family relationships (or substitute caregivers); faulty beliefs about infants; and unsanitary conditions hamper the development of a caring and safe environment. Communications and trust fail to develop. The infant, as a result, often endures a lasting handicapping condition.

Sensory Motor Behavior. In many ways, the infant presents an amusing daily panorama for adults. Sucking behaviors gradually include any

number of objects, surfaces, and liquids. The sucking behaviors are an infant's exploration and practice play. They also meet his physical and psychological needs and are the most intense in the first three months.

Placing pacifiers in baby's mouth at times when baby is not really demanding such prevents mouthing, sucking, and babbling. These behaviors provide baby discovery of attributes of shape, texture, taste, and sound. Pacifiers (and too much thumb-sucking) decrease information-seeking by this new learner.

Visual searching moves from faces to close objects and then on to familiar shapes at a distance.

During infancy, the variety of behaviors change at the most rapid rate of development ever observable in the human species. Removing baby's clothes to only a diaper allows baby more skin area for processing similarities and differences in the surfaces, the space, and the objects around him.

First babies tend to be subject to conditions approaching almost sterile cleanliness. This often prevents parents from letting babies explore grass, dirt, cement, astroturf, or pebbles on their hands and knees. Babies clean up quite well and they tolerate the various ground coverings when exposed to them.

Parent Responses. Holding, touching, rocking, looking into the baby's face, verbalizing positive feelings about the baby, and talking or singing to the baby are all important adult responses with any infant. These can be concentrated times at the diaper change table, at feeding time, or at play time. The significant factor is that they occur. Talking positively about the baby helps others to find the special delightfulness of your baby.

Behaviors To Solicit. Behaviors to encourage in baby are visual focusing, mouthing, reaching, touching, babbling, sitting, transferring, and

smiling. Providing opportunities for your baby to engage in discovery reaps multiple dividends. Every sensory experience during these months is a building block of the child's developing intelligence and personality. The infant is a learner. The right to an appropriate education begins at birth.

Significant Behaviors. Figure 1 includes many important developmental skills. These can serve as a guide for you in planning activities and can help you be aware of any developmental delays. Each child is unique and develops at his own rate. Around six months, the infant should be smiling, sitting unsupported, transferring objects from hand to hand, and babbling such consonant sounds as "da da" and "ma ma." Crawling follows. Crying should be decreasing. Pre-

Figure 1

| | Physical Development | Visual Perception | Language | Social | Intellectual Development |
|---|---|---|---|---|---|
| 0 - 6 mos. | *Equality of movement both sides<br>*Lift head<br>*Roll over<br>*Sit up | *Visually follows objects<br>*Hand<br>*Grasp and release objects<br>*Hands together<br>*Transfer objects | *Turns to sudden sounds<br>*Gestures accompanied by smiling, laughing, crying<br>*Turns to own name<br>*Utterances, babbling | *Parent's holding, develops attachment<br>*Look at self in mirror | *Sensory awareness<br>mouthing<br>visual imagery<br>auditory<br>*Responds to familiar voices, faces, objects, tastes, smells, textures |
| 6 - 12 mos. | *Crawling<br>*Climbing<br>*Walking | *Pat<br>*Knock down<br>*Scribbling without looking | *Imitation<br>*Mama-Dada<br>non-specific<br>specific | *Recognize other adults<br>*Self-help (begin with carrying own diaper)<br>Now pulling off sock | *Remembers an object removed from sight<br>*Can learn:<br>Pat-a-Cake<br>Bye-Bye<br>Peek-a-Boo |
| 12 mos. - Two | *Running<br>*Jumping<br>*Throwing | *Stack objects<br>*Place objects inside each other<br>*Puzzles<br>*Names his drawings | *Approximately has 50 words<br>*Extending to two and three word sentence<br>*Adding prepositions | *Plays with other children when supervised | *My things<br>*Colors<br>*"No" more often |
| Two - Three | *Pedaling<br>*Balancing | *Drawing a 3 - 6 part man<br>*Naming clay and block structures<br>*Recognizes a familiar object when a part is missing | *Can tell two to three sentences about his activity<br>*Asking who, what, where, why<br>*Conversational | *Recognizing familiar community businesses | *Repeating number words<br>*Can say "two" after looking at a group of two objects |

academic skills are fostered through "Pat-a-Cake" and other songs and finger plays. Objects become permanent visual memories. Attachments to people and animals develop. The name of a family pet may become the infant's first word.

If your six month old baby does not transfer objects, sit unsupported for several seconds, and show signs of babbling consult with your pediatrician. Early identification of problems brings both baby and parent help for coping with what could be a potential learning handicap.

Planning Activities. Orienting baby to his surroundings provides novelty for the infant. Activities such as opening and closing a cupboard door will fascinate one infant for an extended period of time. Banging a tin pan with a wooden spoon will trigger another's attention. Pushing water back and forth across the highchair tray will command concentration for still another. Crawling over pillows, cushions, boxes and finally up and down steps has great appeal. Mirrors generate long dialogues for baby with self.

Be flexible and imaginative in planning activities for your infant. A new roll of scotch tape can be a hilarious example of infant manipulation. Each child is unique and not all materials appeal equally to all children.

Over-stimulation, such as too loud and too sudden a noise, too many people, too much diversion from the daily schedule, and too many new materials, can create undue stress for the infant. Stress deteriorates into fussiness, crying, and refusing to eat or sleep.

Every baby is an individual willing to share his state of dependency with a caring parent. The communication established is conditioned by being attuned to baby's needs. The parent must be willing to be a follower in order to become the trusted leader.

When parents see the expansion of their young opportunist as totally dependent on their investment of time in observing, responding, recording,

planning, providing, and expecting, the shared experience can be equally enriching to infant and parent. Finding value in shouldering total responsibility for interpreting the communication of baby requires quietness of spirit and soul. Servitude to this infant dictator is rewarded by a recognition smile, by a spontaneous "hi," and by the warm cuddling in the protecting circle of the parents' loving arms.

## The Demanding Toddler

Recognize the need for your toddler to be physically active in an environment that is both stimulating and safe. Competency results from many opportunities of trying; from repeatedly receiving encouragement when it is needed; and from consistent enforcement of limits. The toddler who continually confronts hostility or rejection develops self feelings of doubt and shame.

Physical Appearance. The toddler still looks like the infant. His head is still larger than the rest of his body. His body is soft with a round little tummy.

In many ways the toddler still behaves like the infant. He pokes, tastes, grabs, cries easily, and may require a morning as well as an afternoon nap.

The transition from the security and familiarity of home and family to new situations continues to cause the child stress. This is observable for a large number of children until they are three years old.

The right and wrong of every situation rests on the individual wants and desires of the toddler. Failure to see another child's right or need is not being a naughty child. This age only perceives a matter from their own point of view.

Language. Negatives are a new and fascinating way of demonstrating his newly discovered toddler power. The toddler may arch his back, throw himself on the floor, or kick at the slight-

est provocation. "No, no" is scattered throughout the day's communication. A favorite response to questions is often "I don't know."

Language acquisition erupts as a verbal explosion for most toddlers. If the toddler isn't testing and playing with the words and labels he already knows, the parent is repeatedly plagued with the question, "What's that?"

Favorite words for beginning sentences revolve around personal pronouns "me," "mine," "my," and eventually "I." Referring to the toddler by name, "Chic" or "Marcee," contributes to a better knowledge of self than do words that express endearment ("lovely," "cutie") or disgust ("stinky," "meanie"). Labeling the child's possession with statements such as "This is Marcee's room; this is Chic's teddy bear" also help toward the child's knowing it's okay to be me.

Studies show that repeating a new word clearly, then including the word in a sentence, supports successful mastery of language by the

child. A parent should talk with the toddler and expect the child to respond. There is ample reason for concern when a child is having limited success. (See Figure 1.) The parent should make an appointment at the earliest possible date with a physician who specializes in eye, ear, and nose problems of children.

A good collection of children's nursery rhymes, fairy tales, and picture books are a must at this age. Let the child tell you the story. Occassionally leave out key words for the toddler to supply. Sing story songs such as "Hush Little Baby, Don't Say a Word." Provide variety with good quality records and tapes.

Motor Behavior. The toddler is intensely interested and observant of all activity near him. Imitating with similar behavior usually follows. Any noise that can be added to the situation increases the child's pleasure.

The constant action of this age child demands constant supervision. Walking, climbing, and running are the visible motions of healthy development. Yet it is these physical skills that allow children to discover the most unbelievable dangers. All cupboards and drawers with poisons, detergents, cleaning supplies, knives, and tools must be placed under lock and key. Assuming that your toddler will be the one to drink the toilet bowl cleaner is the best policy. Secure all cupboards for the child's safety.

Changing land surfaces and floor coverings contribute to the child's negotiating self in space. Inclines, depressions, gravel drives, blacktop, stairs, carpeting, polished floors, wood, ledges, and planter edges demand different balance and maneuvering. The center of balance changes as the child goes from crawling to walking, and again when the child exchanges diapers for training pants. Establish the habit of visiting parks, zoos, and museums, not only for their academic values, but also for their positive motor experiences. Carry your infant and toddler the minimum--when needed for safety and health.

Visual Perception. Eye and hand coordination emerges as a focus for table top activities. Feeding self; using crayons, clay, pencils, pens, and magic markers; building with blocks; helping to dress self; turning knobs, pages of a book; and throwing and catching claim daily attention.

The Older Toddler. The older toddler may present some very difficult and trying times for parents during the self-feeding, learning-to-dress himself stages, and toilet-training stages.

For the toddler this may be a time for quickly demonstrating self-control or for experiencing great frustration.

The more independent and capable the child can become:

in handling his limbs and body;

in sustaining a determination to investigate the possibilities of new materials or a new situation;

in communicating his needs, feelings, and observations;

in recognizing similarities and differences; and

in exhibiting a sense of humor,

the greater will be his self-esteem. Parents' maintencance of a ready sense of humor helps cleanse a potentially explosive atmosphere too.

The unmeasurable reward of the toddler is his trusting and loving abandonment to your holding a book for him, hugging him as you tuck him in bed, or spontaneously tossing him in the air for his sudden suspense.

## The Living-Learning Environment

The home is a rich learning environment. An array of living-learning opportunities exist prior to the addition of any commercial equipment or toy. The innovative parent can turn every space and shape into a dramatic experience.

Indoors. Kitchens and gardens are gold mines for sensory experiences. Have you ever noticed the activity level in the kitchen? Smells abound and change throughout the day. Telephones, voices, running water, dishwashers, and the refrigerator motor break the silences. Wood, water, metal, plastic, linoleum, glass, cloth, paper, and edibles are among the wealth of available textures. Colors, doors, chairs, foods, equipment, and tools are among the images to be gazed at and imprinted on the brain. Words for hundreds of objects may be heard, imitated, and mastered. Cups, plates, spoons, forks, napkins, etc. can be grouped together. Combining infants' actions on kitchen equipment increases an untold realm of happenings, i.e., banging the wooden and then the metal spoon on the metal mixing bowl.

Use the learning experiences available in your home. The home of one baby includes the living areas shown in Figure 2 and provides the multiple learnings that have been checked. Use your home. With chart in hand, make a mental note of the variety in each checked square that can be one of your baby's experiences. Then determine to use what you see for increased learnings.

Figure 2

Learning Opportunities

| Living Environments | Activity | Passitivity | Smells | Sounds | Textures | Visual Imagery | Labels | Classification |
|---|---|---|---|---|---|---|---|---|
| Kitchen | X | | X | X | X | X | X | X |
| Dining Room | | X | X | X | | X | X | X |
| Living Room | | X | | X | X | X | X | X |
| Den | X | | | X | X | X | X | X |
| Bedroom | | X | | | X | X | X | X |
| Utility | X | | X | X | X | X | X | X |
| Sewing Area | X | X | | X | X | X | X | X |
| Bathroom | X | X | X | X | X | X | X | X |
| Office Area | | X | | X | X | X | X | X |
| Music Area | | X | | X | | X | X | X |
| Basement | X | | X | X | X | X | X | X |
| Garage | X | | X | X | X | X | X | X |

Recipes and Things. Appendix C includes recipes for making play dough and finger paint; paper products that are adaptable for the painting experience; and tools that can be used for painting. These already abound in the home. A sequenced selection of rhymes has been included to use with your infant and toddler. These will trigger memory of other finger plays for parent and baby. Exchange ideas with parents of other infants and toddlers.

Outdoors. The outdoor parameter of the home expands the multiple sensory opportunities for your baby. (See Figure 3.)

Tires allow baby to be placed in a position to observe the surrounding activity of nature and machinery long before he has the back control needed to sit. Moving leaves, shadows, waving branches from a soft breeze capture the infant's attention for long periods of time. A passing car, the running dog, the slow moving tractor are stimulators that only the time spent in the yard may provide.

Opportunities to feel dirt, rocks, grass, bricks, sand, cement, bark, leaves, and sticks are for infants and toddlers who are being supervised. Small containers and buckets allow rocks, leaves, acorns, feathers, sticks, and flowers to be collected by the toddler. Water hoses, brooms, ledges, fences, wagons, logs, and riding toys stimulate imaginary play. Mud, falls, cuts, bruises, and tears are to be expected. When did learning not bring some pain?

Dogs, kittens, rabbits, chipmunks, birds, horses, cows, pigs, ducks, goats, and chickens may be among the animal friends that your home offers for your infant or toddler. Healthy maintenance of your animals, adequate records of the animals' shots, and close supervision will make these pleasurable experiences.

The porch may have textures of astroturf, brick, metal, wood, and cement for the exploring hand of the crawler. Additionally, there may be a step or two to crawl up or down.

A brick wall on one side and a flower garden on the other side may border the ribbon of sidewalk at the bottom of the porch.

To neglect the learning dynamics from gardens is unnecessary. The youngest toddler enjoys the dirt play of setting out a flower, the concentration required for picking the red strawberry, and the testy effort demanded for walking in the row.

Figure 3

Learning Opportunities

| Living Environments | Activity | Passitivity | Smells | Sounds | Textures | Visual Imagery | Labels | Classification |
|---|---|---|---|---|---|---|---|---|
| Porch | X | X | | | X | X | X | |
| Sidewalk | X | | | X | | X | X | X |
| Driveway | X | | | X | X | X | X | X |
| Gardens | X | X | X | X | X | X | X | X |
| Lawn | X | X | X | X | X | X | X | X |
| Animals | X | | X | X | X | X | X | X |

The living-and-learning environment of the home is rich in changing mediums for exploring and experiencing. The coordinator-parent maximizes the opportunities.

## Developmental Skills Checklist

Waiting for your baby or toddler to show an attempt, if not the expected behavior, is a worthy occupation of parents who want to enrich the quality of their time with their baby. Recording the date baby achieved a particular mastery of self in relation to space, materials, and others is rewarding. A month to month record of baby's progress is a treasure to be passed on when baby is an adult.

The guide (Figure 1) is intended to show that progress occurs in various areas simultaneously. Babies are individual and develop along their own unique pattern. Charting your infant and toddler's changes reminds you of the next skill baby is or will eventually be mastering.

Learning occurs in varying degrees of extent and approach. Some babies spend longer in one phase of mastery than another. Most babies, however, observe first, then explore and manipulate. Another way of saying the same thing is to say that curiosity is followed by problem-solving. Observe your baby discover his hand for the first time and then notice how long he practices holding it in front of his gaze before he extends the mastery to new uses. Allow baby practice time without intervention. Introduce novelty at his beckon to you.

## Purchasing Toys

Commercial toys contribute to your child's development as well as pleasure. They easily strain and drain the budget. A toy purchase should be well planned. It should meet a need that household items of junk and throwaways cannot meet. Home-made toys, to make the time investment and cost of materials justifiable, should meet

the same criteria as manufactured ones. Toys should be checked for raw edges, parts or pieces that are glued on, and for pins or small pieces from the interior of a toy. Items that can be washed in the dishwasher or washing machine merit consideration. Balls, mirrors, music boxes, busy boxes, puzzles, and riding toys bring dividends. Most other needs can be met by household items or junk.

## Valuable Junk

A tire can be covered with a blanket to provide a secure, upright playspace. Pillows of all sizes initiate creative ways of propping baby to encourage moving. Lids of all sizes fascinate

baby for long periods of time. Plastic buckets, plastic lids, empty medicine vials, and food tins make multiple play materials. Discarded neckties, scarves, and hats give special pleasure. Logs of different heights convert to graduated stepping stones. Milk cartons make wonderful blocks.

## Play Mediums

Playdough, liquid starch, shaving cream, and commercially prepared finger paints are necessities which require close supervision. Water, dirt,

sand, saw dust, styrofoam, wood scraps, boxes, bags, and dress-up clothes create endless hours of involvement in imagination and energy.

## Child Care

Parents of infants and toddlers need child care occassionally, for part of a day, and now many parents are seeking care for their infant for ten-to-twelve hours per day. Principles to be observed include 1) consistency in the substitute care-giver, the substitute environment, and the schedule; 2) observance of health and safety practices; 3) an appropriately stimulating environment (refer to living-learning centers); 4) nutritious meals; and 5) a warm welcome to unexpected visits from parents.

## Summary

The cycle of life returns beauty and joy to those who are able to enjoy childhood revisited through the expericnces they share with their children. Neither philosopher nor prophet has predicted a future void of the young. The quality of the childhood depends upon committed acceptance of assumed responsibility through adult action. Make your child's growth and development an exciting adventure--shared.

BIBLIOGRAPHY

Biller, H. & Meredith, D. Father power. Garden City, NY: Anchor Press/Doubleday, 1975.

Brazelton, T.B. Infants and mothers: differences in development. New York: Dell, 1969.

Brazelton, T.B. Toddlers and parents: a declaration of independence. New York: Dell, 1974.

Caplan, F. & Caplan, T. The power of play. Garden City, NY: Anchor Press/Doubleday, 1973.

Coonrod, D. & Bradshaw S. Just infants: developmental skills and activities. Bloomington, IN: Debcon, 1980.

Coonrod, D. & May, M.A. Just toddlers: developmental skills and activities. Bloomington, IN: Debcon, 1980.

Dodson, F. How to father. New York: Signet, 1975.

Gordon, I.J. Baby learning through baby play. New York: St. Martins, 1970.

White, B.L. The first three years of life. Englewood Cliffs, NJ: Prentice Hall, 1975.

# 3

# THE INFANT-TODDLER NUTRITION STORY

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Both audio tapes and television tapes are among her credits in the field of nutrition. As a nutrition consultant with the Indiana State Board of Health she is a favored and frequently sought speaker regarding family nutrition.

Your baby is here, and you are ready to enjoy him or her. Enjoying your baby may seem like an unlikely opportunity when your mind is full of feedings, birth weight, and so many other new things which mother needs to learn about the new baby in the family. Getting enough to eat, feeling safe and warm, are about all a new baby needs. The baby knows he will be responded to when he cries. Food and love are about equally necessary; and when both are freely available, the baby will thrive and be happy.

The baby cries when hungry. He frets when his brief trials at getting some satisfaction out of his fist have failed. His whole world is empty; not just his stomach. You, the mother, come along with the complete answer -- food. In providing the food you are giving your baby love by holding and loving him. Be it breast or bottle, the nipple is the source of most of his happiness. He plunges into sucking.

For both you and the baby, milk is more than nourishment. Feeding has become a language between you and your child. It tells the baby that when he is hungry, you will bring him milk. He later learns that whatever he needs, you will be there to try to comfort him. These are the first lessons for baby about the world around him.

Your baby talks to you through his behavior with the milk you give him. As he thrives with the milk you offer and begins to respond to you, you grow in regard for him.

## Baby's First Feeding

Doctor Samuel J. Fomon, Professor of Pediatrics, College of Medicine, University of Iowa, recommends a Vitamin K and water preparation be administered to the baby soon after birth. The baby is then given his first feeding of distilled water. If at least 15 milliliters of water is retained, then the breast or formula feedings are started. (American Academy of Pediatrics, 1979). Thereafter, the baby is fed every three to four

hours for the first week. No attempt should be made to encourage the infant to accept greater amounts of food than seem to satisfy him. Bottle-fed infants should not be encouraged to drain the last drop from the bottle. Toward the end of the first and second weeks, most infants begin to settle down to feedings that are three to four hours apart. No medical or nutritional advantage has been shown in reducing the number of feedings to less than five per day during the first four months of life. (American Academy of Pediatrics, Committee on Nutrition, 1976.)

Your baby will have special feeding needs because of his rapid growth. During your baby's first year of life he should double his birth weight by the fifth or sixth month of age and triple his birth weight by one year of age. He will probably grow ten to twelve inches in length by the first year.

The vital organs of the baby's body grow very rapidly during the first year of life. Only if the baby's feedings contain enough of the essential nutrients and calories will baby's growth occur. Calories should be provided with an appropriate balance of protein, carbohydrates, and fats, plus vitamins and minerals. Calories are the fuel which give your baby his energy, health, and growth.

## Breast Or Bottle Fed?

The first question that an expectant mother asks is, "Should I breast or bottle feed my baby?" You probably examined all sides of this question before you made your decision.

Human milk is the ideal food for babies; commercially prepared formula is very much like human milk and infants grow and thrive on it. Breast feeding has some benefits not found in formula. Human milk provides natural immunity against infection. Breast-fed babies also seem to have less colic and fewer upsets. Breast-fed babies have also shown less allergies to human milk than to formula.

Breast feeding is also convenient and the only cost is for additional food for mother that includes whole grains, low-fat dairy foods, poultry, vegetables, and fruit. The milk is readily mixed, at the proper temperature, instantly available, and in a sterile container. The baby is able to suck until he has enough; he is not forced to clean up the last drop.

Breast feeding has some other advantages for the new mother. Nursing stimulates the uterus to shrink to normal size after delivery. In addition, milk production requires calories which may help the mother return to her pre-pregnancy weight more rapidly.

Both human and cow's milk are naturally low in iron and Vitamin D. Iron and Vitamin D are essential to normal growth. Although healthy babies are born with a three-month supply of iron,

the amount the fetus is able to store is dependent upon its mother's supply. An iron supplement is usually prescribed for a breast-fed baby. For a bottle-fed baby, mothers are urged to select a

formula containing iron. A daily supplement of 400 IU (International Units) of Vitamin D for the breast fed baby and for the baby on unfortified milk formula is usually recommended. (Fomon, 1974.)

The Council on Dental Therapeutics of the American Dental Association recommend that no supplementation of fluoride be given if the water contains 0.6 or more parts per million of fluoride. The level of fluoride in the water supply is available from the local health department. (Columbia University, 1980).

If mother is breast feeding her baby, she may feel that some freedom of activity is important for her. A daily formula feeding does not interfere with the success of nursing.

Sometimes, it is impossible or unwise to breast feed your baby. If you work or are away from home nine to ten hours each day, formula feeding is usually best. With a doctor's guidance, choose a fortified formula that is similar to breast milk. Commercially prepared formula is a complete food for infants and requires no supplement of vitamins and minerals.

Your decision was made to breast feed or bottle feed. Whatever the choice RELAX AND ENJOY YOUR BABY!

## Formulas

Infant formula can be divided into three categories: Milk based formula, soy based formula, and specialized formulas.

The protein source of milk based formula is cow's milk, and for soy based formula the source is soy protein. All or most of the fat in both formulas is provided by vegetable oils. The milk based formulas contain lactose (milk sugar) as the major carbohydrate. It seems to make little difference for the healthy, full-term infant, whether a formula is based on cow's milk protein, or a mixture of cow's milk protein and/or soy protein. (ESPGAN Committee on Nutrition, 1977.)

Soy based formulas have been developed to aid in dietary management of one of the following principles:

1. Infants who are allergic or are suspected to be allergic to cow's milk protein.
2. Infants with galactosemia (high levels of galactose in the blood). Galactose is a simple sugar.
3. Infants with lactose (milk sugar) deficiency.

## Specialized Formulas

There are a few infants who can not tolerate human milk, cow milk based formulas, or soy based formulas due to disorders of digestion, of absorption, or of metabolism. These infants must have a select special formula ordered by the physician and dietitian that meets the infant's needs so he will grow and develop as he should. (ESPGAN Committee on Nutrition, 1977.)

If you plan to bottle feed your baby, your doctor will recommend a prepared formula. Keep your baby on the formula for at least six months and preferably one year. The following schedule is an example of infants fed from birth to six months:

Suggested Feeding Schedule for Infants (Birth to 6 Months)

| Time of Feeding Schedule | 1 mo. | 2 mo. | 3 mo. | 4 mo. | 5 mo. |
|---|---|---|---|---|---|
| Amount of Formula | 14-28 oz. 24 hrs. | 23-34 oz. 24 hrs. | 25-40 oz. 24 hrs. | 27-40 oz. 24 hrs. | 27-45 oz. 24 hrs. |
| 6:00 a.m. | 2 - 4 oz. | 4 - 6 oz. | 4 - 7 oz. | 6 - 7 oz. | 6 - 8 oz. |
| 10:00 a.m. | 2 - 4 oz. | 4 - 6 oz. | 4 - 7 oz. | 6 - 7 oz. | 6 - 8 oz. |
| 2:00 p.m. | 2 - 4 oz. | 4 - 6 oz. | 4 - 7 oz. | 6 - 7 oz. | 6 - 8 oz. |
| 6:00 p.m. | 2 - 4 oz. | 4 - 6 oz. | 4 - 7 oz. | 6 - 7 oz. | 6 - 8 oz. |
| 10:00 p.m. | 2 - 4 oz. | 4 - 6 oz. | 4 - 7 oz. | 6 - 7 oz. | 6 - 8 oz. |
| 2.00 a.m. | 2 - 4 oz. | *4 - 6 oz. | *4 - 7 oz. | | |

*Some babies may need only 5 feedings per day.

This is a guideline. Each child will grow at a different rate, but remember: (State Board of Health Feeding Guidelines, 1978.)

1. Formula is the most important food for the baby.
2. Use of iron fortified formula is recommended by the American Academy of Pediatrics.

If you bottle feed your baby the bottles and nipples must be sterilized (Appendix A). Use the formula prescribed within 24 hours of preparation. Put only the amount of formula into the bottle that you judge baby will consume. Seat yourself in a comfortable chair and hold the baby in your arms while giving him the bottle. Never prop your baby's bottle while feeding. Always hold the bottle tilted with the neck of the bottle and nipple filled with the formula. This is to keep the baby from swallowing air.

The baby does swallow some air in both breast feeding and bottle feeding. Burping the baby helps to get rid of the swallowed air. Hold the baby upright over your shoulder and pat or rub the back gently until the baby burps.

## Water

It is important to give your baby water. Be sure it is safe for baby to drink. Boil the water for ten minutes and then allow to cool. Store the water in the sterile nursing bottle. Do not add sugar or corn syrup. Too much sugar is not good for your baby. Two to three ounces of sterilized water can be given to baby each day. (Fomon, 1974.)

## Mother's Diet

When mother selects to breast feed her baby, it is important that she eats an adequate diet so she can provide for her baby's needs. It is also important for mother to drink plenty of fluids and to get enough rest. The following is a guide for a nursing mother's daily diet:

Foods for Lactating Woman (Dairy Council Digest, 51:2, 1980)

| | |
|---|---|
| Milk | 6 cups |
| Meat, fish, poultry (liver once a week) cooked weight | 4 ounces |
| Eggs | 1 |
| Vegetables, including: | |
| Dark green leafy or deep yellow | ½ cup |
| Potato | 1 medium |
| Other vegetables | ½ - 1 cup |
| One vegetable to be raw each day | |
| Fruits, including: | |
| Citrus | 1 serving |
| Other fruit | 1 serving |
| Cereal, enriched or whole grain | 1 serving |
| Bread, enriched or whole grain | 5 slices |
| Butter or fortified margarine | To meet caloric needs |
| Desserts, cooking fats, sugars, sweets | |
| Vitamin D supplement (or use fortified milk) | 400 I.U. |
| Iodized salt | Daily |

## Solid Foods

It is wise to not add solid foods or juices to your baby's diet too early. Breast milk and vitamins or iron-fortified formula will provide all the nutrients your baby needs until after six months of age. Although babies may tolerate solid foods earlier, there is no evidence that they are nutritionally beneficial. (Dairy Council Digest, 51;1, 1980.) Babies who are fed solid food (pureed baby foods or commercially prepared baby foods and cereals) at an early age may tend to be overfed, develop unsound food habits, and become obese. Also, these babies tend to be babies who develop allergies. (Fomon, 1974.)

Your baby is growing. Your breast milk or iron-fortified infant formula is still giving your baby most of his nourishment. But now he is six months of age and ready for a new eating experience. He is ready to sit up and grab a spoon. Be sure to keep up his good nutrition by giving him good food when he starts solid foods.

Cereal is usually the first solid food introduced at six months of age. Rice cereal is first, followed by oatmeal and barley. Wheat cereal is last, as young babies frequently develop an allergy to wheat. Mixed cereals should be introduced after all other cereals have shown the baby is not allergic to one or more grains. Use iron-fortified dry baby cereal. Add only formula, breast milk, or water. Never, never add sugar or salt to the cereal.

A Vitamin C fruit juice (orange, apple, grape) is also introduced around six to seven months of age. At around seven months of age, vegetables are introduced. (State Board of Health Feeding Guidelines, 1978.) Use canned, unsalted, strained vegetables or mash your own plain unsalted vegetables. Start with carrots, squash, peas, or beans. Later add greens. Do not add margarine, butter or any other kind of fat or salt in the baby's vegetables. Baby food fruit like applesauce, pears, or peaches or home-mashed fresh fruits like bananas, are very good. Never add sugar to baby's fruit. At around nine months, you may add protein foods such as strained baby lamb, beef, veal, chicken, or liver (no dinners). Dinners are low in protein and high in carbohydrate. You may mash or puree homemade navy beans, chicken livers, plain meats or fish. You may mash hard boiled egg yolk. Do not add fat of any kind or salt to baby's meat.

The following is a guideline to feed the six month to twelve month old child. (State Board of Health Feeding Guidelines, 1978.)

Suggested Feeding Schedule for Infants (6 months to 12 months)

| Age | 6 mo. to 7 mo. | 7 mo. to 8 mo. | 8 mo. to 9 mo. | 9 mo. to 10 mo. | 10, 11 an 12 mo. |
|---|---|---|---|---|---|
| Amount | 24-32 oz. 24 hrs. | 24-32 oz. 24 hrs. | 24-32 oz. 24 hrs. | 16-24 oz. 24 hrs. | 16-24 oz. 24 hrs. |
| Time | | | | | |
| 6:30 a.m. | 6 oz formula | 6 oz formula | 6 oz formula | 6 oz formula | 6 oz formula |
| 7:00 a.m. | 2T dry cereal with formula | 2T dry cereal with formula | 2T dry cereal with formula 2T strained fruit | 2T dry cereal with formula 2-3T mashed fruit | 2T dry cereal with formula 2-3T mashed fruit |
| 10:00 a.m. | 2 oz Vitamin C fruit juice | 3 oz Vitamin C fruit juice | 3 oz Vitamin C fruit juice | 3 oz Vitamin C fruit juice | 3 oz Vit. C fruit juice 1 cracker or dry toast |
| 12:00 noon | 2T dry cereal with 6 oz formula | 2T dry cereal 2T strained veg. 6 oz formula | 2T dry cereal 2T strained veg. 2T strained fruit 6 oz formula | 2-3T mashed veg. 2-3T mashed fruit 2T strained meat 4 oz formula | 2-3T mashed veg. 2-3T mashed fruit 2-3 strained or chopped meat 4 oz formula |
| 3:00 p.m. | 6 oz formula | 6 oz formula (by cup if ready) | 6 oz formula (by cup) | 6 oz formula (by cup) | 6 oz formula (by cup) 1 cracker or dry toast |
| 6:00 p.m. | 2T dry cereal with formula 6 oz formula | 2T dry cereal 2T strained veg. 6 oz formula | 2T dry cereal 2T strained veg. 2T strained fruit 6 oz formula | 2T dry cereal with formula 2-3T mashed veg. 2T mashed fruit 2T strained meat 4 oz formula (cup) | 2-3T mashed veg. 2-3T mashed fruit 2-3T strained or chopped meat 1 cracker or dry toast 4 oz formula (cup) |
| 10:00 p.m. | 6 oz formula | May start sleeping throughout the night. | | | |

Following are some key factors to remember in feeding your baby from six months to one year:

1. Solid foods (dry cereals, fruit juices, and commercial or home prepared strained baby foods) are introduced about six months of age.
2. Measure one teaspoon cereal and mix with two tablespoons of breast milk, water, or formula to start.
3. Start slowly; give less than a teaspoonful of the new food. Every day, give a little bit more until he takes a tablespoon or two at a feeding.
4. Add new foods one at a time and wait a week before starting another.
5. Do not put baby to bed with a bottle. It is bad for his teeth and might choke him. It is a difiicult habit to break.
6. Babies often begin teething around six months. Some hard, dry toast or biscuit may help. Avoid giving the baby cookies.
7. Formula and juice may be offered by training cup when child is ready.
8. Formula is used (in a cup when child is ready) until 12 months unless otherwise stated by the physician.
9. Only plain, strained vegetables, fruits, and meats are offered.
10. At each meal, take out of jars only the amount of food you are going to feed your baby. Seal the jar back and refrigerate.
11. Throw away open jar of baby food after two days old.
12. Do not urge baby to eat too much.
13. If your baby is gaining too fast, check with your doctor, dietitian, or nurse.

14. Twenty mintues is a good length of time for the feeding of your baby.

15. Provide a calm, happy meal time. Do not rush the baby. If he does not accept one food, let him try it in a few weeks.

16. Many babies are ready for foods of coarser consistency after nine months of age. Mashed or chopped foods may be used.

17. Finger foods may be offered around 11 and 12 months.

Toddlers One Year To Two Years

During the first year your baby was eating and growing very rapidly. However, your toddler's eating and growing will slow down during the second year. At some meals he/she may not want to eat at all. This is normal and is to be expected because of your toddler's slower growth rate.

By this time your toddler has begun his transition from strained to coarse food. Commercial Junior foods may be useful for you if you are a working mother who wants control over what the babysitter feeds your toddler. When the family meal is unsuitable for the toddler, commercial foods may again be convenient. Mashed or chopped foods from the family table are more economical. When giving your toddler table food, salt and/or fats should not be added when preparing for the family until after the toddler's portion has been removed. Studies have shown toddlers accept food without salt as readily as they do with salt added. (Pediatric Nutrition Handbook, 1979.)

The toddler is ready at this age to eat three meals a day with planned snacks. He/she should be eating a variety of foods; chopped, mashed, or cut into bite size pieces from the family table. You should continue to purchase iron fortified cereals to provide the necessary iron for your toddler. Bread, toast, and plain crackers are better for the toddler than sweet rolls or cakes. Diets for many toddlers are lacking in fruits and

vegetables. Since life-long food habits are formed at an early age, the toddler who has an opportunity will enjoy the taste of a variety of fruits and vegetables and will be more likely to continue to eat a variety of foods as an adult. Strips of tender meats, cheese, fruits, and vegetables make finger feeding easier when a child is learning to feed himself. Cookies, candy, cakes, colas, powdered fruit-flavored drinks, and other high sugared foods have no place in the toddler's diet. A variety of foods from the four food groups will provide the essential nutrients for the toddler. (Appendix B).

Milk--two cups (½ cup per serving)

Meat or meat alternatives--two or more servings (1-2 tablespoons per serving)

Fruit and vegetables--four or more servings (1-2 tablespoons per serving)

Bread and cereal--four or more servings. (½ slice of bread or ¼ cup cereal per serving)

A rule of thumb for serving sizes is about one tablespoon of food for each year of age.

Translation of the four food groups into toddler's daily menu is shown in Chart 5. (State Board of Health Feeding Guidelines, 1978.)

Suggested Feeding Schedule for Toddlers

Age 1 year to 2 years

| Time | Foods Offered | Amount |
|---|---|---|
| Morning | Fruit or Orange Juice | ½ cup |
| | Cooked Cereal (Iron fortified Cream of Wheat) | 4 Tablespoons |
| | Toast | ½ slice |
| | Milk | 4 oz. |
| A.M. Snack | Citrus Fruit or Citrus Juice | ½ cup |
| Noon | Meat (Meat Loaf) | 1-2 Tablespoons |
| | Starchy Vegetable (Mashed Potato) | 1-2 Tablespoons |
| | Cooked Vegetable (Green Beans) | 1-2 Tablespoons |
| | Fruit (Peach) | 1-2 Tablespoons |
| | Bread and Margarine | ½ slice |
| | Milk | 4 oz. |
| P.M. Snack | Milk | 4 oz. |
| | Cracker | 1 |
| Night | Meat (Peanut Butter) | 1-2 Tablespoons |
| | Vegetable (Cooked carrot coins) | 1-2 Tablespoons |
| | Vegetable or Salad (Celery stick) | 1-2 Tablespoons |
| | Bread and Margarine | ½ slice |
| | Fruit (Banana slice) | 1-2 Tablespoons |
| | Milk | 4 oz. |

While your toddler is learning to feed himself, he should be provided the correct utensils. A small spoon with a short, easy handle is easy to grip. A small cup with no handle and a broad mouth is easy for small hands to pick up. A dish with a rim or side will help your toddler to push food on the spoon. All dishes should be unbreakable.

Toddlers have small appetites. The appetite decline that occurs sometime around the first birthday is a natural consequence of a slower growth rate. An infant gains 18 to 20 pounds in the first year of life, tripling his birth weight. In the second year, the toddler may gain only seven to eight pounds. Potential feeding problems can be avoided if the decreased appetite after the first year is recognized as a normal stage of development.

Some tips parents need to remember about feeding their toddler:

1. Your toddler will enjoy feeding himself by picking up food with his/her fingers. Food should be large enough for your toddler to pick up and hold.
2. Give your toddler small pieces of tender meat, chicken, and cooked vegetables.
3. Select easy to use utensils, such as spoons with short straight handles, cups that will not break, and dishes with rims or sides that the food can be pushed against.
4. A relaxed, pleasant atmosphere is an important part of feeding your toddler.
5. Your toddler should not be coaxed to eat more than he wants; forcing him/her to eat may cause feeding problems later on.
6. Toddlers should be drinking milk from a cup.
7. <u>Some unsuitable foods</u> for toddlers:

   Foods which may cause choking:

   Potato chips
   Berries
   Corn
   Small cookies
   Nuts
   Raw peas
   Popcorn
   Raw carrots
   Unpeeled raw apples

Foods which take the place of more nutritious foods:

Pastry
Cookies
Cake
Candy
Sweet drinks, such as Kool-Aid
Soft drinks
Pop
Other sweet foods

Preschool Children/Age Two To Three

Children's minds and emotions are developing fast. Mothers should try to avoid severe conflicts about food. A child's feelings about his food experiences may affect the way he is able to meet other situations throughout life. Bringing children and food happily together helps contribute to the child's emotional satisfaction and helps the child develop good mental health.

For happy meal times, a two to three year old child needs:

1. Adequate play, rest, sleep, and then clean hands--ready to eat a happy meal.
2. Attractive food served to him.
3. Small servings served on the plate.
4. Some freedom to choose his own food.
5. Some freedom to eat in his own way.
6. Above all, relaxed parents.

Little children like to eat at little tables and be served little portions of foods. An easy way to maintain a balanced diet is to continue with the meal pattern that was suggested for age one, and to gradually increase the serving sizes of each food. The serving size can be increased a tablespoon a year without changing the meal pattern.

A gradual increased need for all nutrients during the growing years are evidenced from the recommended dietary allowance table (Appendix 3) which lists separate averages for each span of three years. A study of the table reveals that a one-year-old toddler needs around 1,000 calories a day; two- to three-year-old children need 300 more calories each day. The table may also reveal that while children certainly need an adequate amount of milk, it can be over-emphasized and can indirectly deprive the child's need of other important nutrients. A balance and variety of foods are needed.

We have mentioned nutrients and the child's need for a variety of food. Let's take a closer look at each. Food is necessary to live, to grow, to keep healthy and well, and for energy to work and play. Food is made up of many components. Protein, carbohydrates, fats, minerals, and vitamins are part of these components called nutrients. All nutrients have a specific job to do in the

body. All nutrients needed by your child's body are available through food; but no one food has all the nutrients for adequate growth and health.

## Nutrients In Foods

Protein foods are absolutely necessary to your child's body. Children must have protein to grow. Protein supplies the nutrients from which muscles, blood vessels, and other parts of the body are built and kept in good condition. The best sources of high quality protein are meat, fish, poultry, eggs, and cheese. Other sources are dried beans and peas, nuts, and peanut butter.

Carbohydrates (starches) give your child energy to work and play. They are found in many of the foods we eat every day. Carbohydrates are found in breads, cereals, wheat, sugar, fruits, and vegetables.

Fats are also energy providing foods. Butter, margarine, cooking fats and oils, salad dressings, cheeses, and meats are sources of fats.

## Vegetarian Diets

There is an increased trend toward the use of Vegan Vegeterian Diets in families. Vegan Vegetarian diets allow for consumption from plant origin only. Thus, mother's are to give no milk or milk products which includes cheese. Mothers are unable to plan into the diet foods like fish, chicken, turkey, eggs, plus any kind of meat--beef, pork, veal, or lamb. Health professionals are seeing more and more children weaned to diets of pure plant origin. The weaned child from the Vegan Vegetarian family may lean toward protein deficiency. Many cases of protein/calorie malnutrition in the United States have been documented.

If mothers from a Vegan Vegetarian Diet family will continue to provide soy-based milk and/or soy-based milk products beyond the weaning period and during all the growth period and provide complement plant protein to form foods which the child will eat, then growth will probably be adequate.

Mother and Dad and all Health Professionals should carefully watch the rate of growth of children growing up in families of Vegan Vegetarian Diets. All should make sure the child's growth is not being stunted through lack of adequate dietary protein.

Vitamins and minerals are necessary to keep our bones, teeth, and hair healthy. They help to fight off germs and disease and keep your child's body working properly.

In-Between Meals

Little children do need in-between meals. The capacity of their stomach is small. They can not hold much food at one time. Foods listed are suitable snacks for small children. Suitable snacks are included into the total daily meal plan.

1. Unsweetened fruit juice
2. Milk
3. Fresh or canned fruits
4. Raw vegetables
5. Small sandwiches
6. Crackers
7. Dried cereal
8. Cheese wedges
9. Toaststicks
10. Cereal mix

The following is a meal pattern for children two to three years old. You can follow the same meal pattern for the entire family by increasing serving sizes. (State Board of Health Feeding Guidelines, 1978.)

| | FOOD ITEM | AMOUNT |
|---|---|---|
| *BREAKFAST | | |
| Fruit or Juice | Applesauce | ½ cup |
| Cereal or Toast | Oatmeal | ½ cup |
| Milk | | 4 oz. |
| A.M. SNACK | | |
| Bread or equivalent | Toast | ½ slice |
| Citrus Juice or Fruit | Orange Juice | ½ cup |
| LUNCH | | |
| Meat, Poultry, Fish or eggs, etc. | Peanut Butter | 2 T. |
| Vegetable | Green Beans | 3 T. |
| Another Vegetable and/or Salad | Tender Cooked Carrot Sticks | 3 T. |
| Bread | Whole Wheat | ½ slice |
| Butter or Margarine | | 1 tsp. |
| Fruit or Simple Dessert | Banana | ½ small |
| Milk | | 4 oz. |
| P.M. SNACK | | |
| Bread or equivalent | Soda Crackers | 2 |
| Milk | | 4 oz. |
| DINNER or SUPPER | | |
| Meat, Poultry, Fish or eggs, etc. | Meatball | 1 oz. |
| Potato or Substitute | Spaghetti | 3 T. |
| Vegetable | Peas | 3 T. |
| Another Vegetable and/or Salad | Lettuce Pieces | 3 T. |
| Bread | Bread | ½ slice |
| Butter or Margarine | | 1 tsp. |
| Fruit or Simple Dessert | Baked Custard | 3 T. |
| Milk | | 4 oz. |
| BEDTIME SNACK | | |
| Citrus Juice or Fruit | Orange Slices | 2 or 3 |
| Bread or equivalent | Crackers | 2 |

*Other items such as egg, cheese, or other protein foods may be served.

Establishing good feeding practices in infancy, as in toddler years and early childhood, influences not only the child's health and development during the early childhood, but also lays a foundation for lasting health.

Good eating habits encourage the child to learn about food, about themselves, about the behaviors that win approval, and about behaviors that do not. Good eating habits also provide nutrients for the child's growth and development. Eating time can make a great contribution to the child's future well-being, both physical and psychological.

BIBLIOGRAPHY

American Academy of Pediatrics. Committee on nutrition. Pediatric, 1976, 57, 278.

American Academy of Pediatrics. Committee on nutrition. Pediatric Nutrition Handbook, Evanston, Illinois; American Academy of Pediatrics, 1979.

Columbia University. Nutrition and health. Institute of Human Nutrition, New York, 2, 3, 1980.

ESPGAN Committee on Nutrition. "Guidelines on infant nutrition." Recommendations for the composition of an adequate and adapted formula. ACTA Paediatrica Scandanavian Supplement 262, 1977.

Fomon, S.J. Infant nutrition (2nd ed.). Philadelphia: W.B. Sanders Company, 1974.

Food and Nutrition Board. Recommended dietary allowances, ninth revised edition. Washington, D.C.: National Academy of Sciences, National Research Council, 1980.

National Dairy Council. Dairy council digest, 1980, 51, 1-2.

National Dairy Council. Dairy council digest, 1980, 51, 2.

New York City Health Department, Bureau of Nutrition, 1977, 410.

State Board of Health Feeding Guidelines, Indianapolis, Indiana, 1978.

The National Research Council, Committee on Nutrition of the Mother and Preschool Child. American journal of clinical nutrition, 1978, 31, 2026.

U.S. Department of Agriculture. Food and nutrition service. Agricultural Research Service. Revised, 1975. Printed by Consumer Services, Public Relations, Ralston Purina Company.

# 4

# MEDICAL AND DENTAL CARE

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**M**edical Care. It is best to choose a doctor for the baby before the baby is born. Mother's obstetrician may recommend someone. The doctor chosen may be a pediatrician or a family practice doctor. Most doctors have a schedule they follow as to when they see infants for their well-child visits. Usually the schedule is at least once during the first month, then every one to two months during the first six months, then every two to three months until the end of the first year. The infant is scheduled for one or two exams during the second year. After the second year, visits are usually yearly. The visits discussed above are considered well-child visits. The child goes to the doctor when healthy so the doctor may do a total exam and answer any questions the parents may have about growth and development. In addition to well-child visits, a visit to the doctor may be needed if the infant becomes ill.

Many communities have well-baby clinics. It is fine to utilize these clinics for the infant's well-child exams. Usually a qualified nurse does the exam and is able to answer any questions the parents have. If utilizing these clinics, arrange to have the clinic records sent to a doctor who will follow the infant in case of illness.

Immunizations. Immunizations are given to the infant during the well-child visits. Immunizations provide protection from diseases. It is recommended that a record be kept of the infant's immunizations. (See inside back book cover.)

Diptheria-Pertussis-Tetanus (DPT) immunizations are given at 2, 4, 6, 18 months and at 4-6 years of age. Every five to ten years throughout school and into adulthood, a person should have a Diptheria-Tetanus (DT) or Tetanus toxoid immunization.

The DPT injection, which is given in the infant's thigh, may cause a fever within 24 - 48 hours and may cause a lump at the site of the injection. The doctor or nurse may advise the parent on how to use Tylenol (Acetaminophen) to reduce this fever. A warm, wet washcloth wrapped around the infant's leg where the injection was given helps to reduce the tenderness and swelling. The lump may persist for weeks. Other side effects of the DPT are uncommon. If any should occur, the doctor should be notified.

The polio immunization (TOPV) is given orally (by mouth). It is given at 2, 4, and 18 months, and again at 4-6 years of age. It is given in a pink sugar solution. Generally speaking, there are no side effects.

A measles, mumps, and rubella (MMR) immunization is usually given as one injection at 15 months of age and need not be repeated. The side effects of the MMR include loss of appetite, rash and fever. The rash is mild and occurs a few days -- usually within ten days -- after the immunization. Again, the doctor may recommend the use of a fever medication after the injection. The warm, wet washcloth will help decrease the swelling at the injection site. If a fever greater than 104° occurs, along with other signs of illness, it is best to talk to the doctor as soon as possible.

Since immunizations can cause side effects, parents may question their use, and may even avoid them. Avoiding immunizations should not be considered for two reasons. First, not every baby will have a reaction to the immunization. Second, the risks and possible consequences of getting the disease as a result of not being immunized far outweigh the short-term discomfort which comes from the immunization.

The health professional will administer a Tuberculin (Tb) test to the baby during one well-child exam. It is administered at 9-12 months. This is <u>not</u> an immunization; it does <u>not</u> prevent tuberculosis. Rather, it is a screening test to

determine whether or not the infant has tuberculosis. It is administered in the infant's forearm, and the parant will be instructed to bring the baby back to the clinic for the reaction to the test to be "read." Or, the parent may be given instructions on how to "read" the reaction and to notify the clinic of the results. TB screening tests are done routinely every one to two years.

Health Record. Many parents find it helpful to take a list of questions with them when they visit the health professional with the infant. The list helps the parent remember questions they have intended to ask the doctor/nurse. Utilize the chart on the back inside cover to help remember the visit and the treatment and advice the health professional gave. It may be helpful to take this book along to note the advice immediately so one does not forget. An example of how to use the chart follows.

Amanda's HEALTH RECORD

| DATE | AGE | WT. | HT. | IMMUNIZATION | FOODS TO ADD | MISC. | ILLNESS | MEDS. | HEALTH CARE PROVIDER | COST |
|---|---|---|---|---|---|---|---|---|---|---|
| 2/1 | 1 mo. | 7 lb. | 19½" | —— | increase formula to 30 oz. day | burp after every 2 oz. | — | vitamins 1 w/d | ABC Clinic | 5.00 |
| 3/2 | 1 mo. | 8 lb. 16 z. | 20¼" | —— | | | cold | decongestant drops Tylenol | Dr. Charles | 10.00 |
| 4/2 | 2 mo | 9 lb. 3 oz. | 21" | DPT #1 DPV #1 | increase formula to 34 oz. day | Healthy! | | | ABC Clinic | 5.00 |
| | | | | | | | | | | |

Teething. Teething, or the eruption of teeth, may begin as early as three monghs, or as late as one year. Most babies begin teething at 6-7 months. The lower central incisors (bottom front) teeth are the first to erupt, followed by the upper central (top front) about a month later. Then teeth on either side of the upper two develop a few months later, followed by two more teeth, one on each side of the two lower teeth. The child will develop twenty teeth by 2½ years of age.

As teeth erupt, the process is usually accompanied by drooling and biting. Some infants have periods of irritability and sleeplessness. Giving the infant something hard to chew on (teething ring, cracker) will help decrease the pain. Something cool to chew may also help (e.g., ice, frozen juice). Rubbing the gums with ice may also help decrease pain. Fever and diarrhea do not usually accompany teething, but they are signs of other illnesses.

## Dental Care

Dental care begins not with the baby's first tooth, but with the first feeding. The most common health problem in children is dental disease. Many dental diseases, including tooth decay and gum infections are preventable. It is important to always feed the baby in a near-upright position, rather than in a flat position. This helps prevent dental caries (cavities) and middle-ear infections (otitis media). The child should be fed in an upright position even when older and able to hold the bottle unaided. Place the baby in a sitting position while drinking the bottle, and allow the infant to finish the bottle before being put to bed.

Flouride is a mineral that is important in firming teeth and in preventing dental decay. It is found in most water supplies. If formula is made with city water, the infant will not need supplemental flouride. If, however, well water

is used or if breast fed, the infant needs a fluoride supplement. Speak to the doctor about a recommended supplement.

Even before the infant's teeth begin to erupt, after each feeding wipe off the gums with a damp, clean washcloth. This helps remove particles of milk and, later on, solid foods. Continue to do this when the teeth erupt. When the child is 18 months old, begin to use a toothbrush in the mouth. Use a small brush with soft bristles. Brush the gum tissue and all sides of the teeth with short, gentle scrubbing motions.

Since toddlers like to imitate, allowing the child to watch the parents brush their teeth makes brushing the teeth (with some parental help) fun to do. Flossing the teeth can be instituted at this time also. Tying a knot in the floss to make a circle helps facilitate the use of floss in the child's mouth. Floss between teeth down into the gum tissue daily.

Eating a well balanced diet including the four basic food groups -- milk, meats, breads, and vegetables -- helps the toddler have healthy teeth. Help the child avoid foods that are high in sugar content. Sweet food (sugar) does contribute to dental disease.

The child's first visit to the dentist should be when all twenty teeth are in (about 2-3 years of age) and should be a "fun visit." Many dentists now specialize in treating children, and the parent may want to check in the community for such a dentist. On the first visit the child should be allowed to meet the dentist, investigate the chair and listen to the drill in a very non-threatening atmosphere. If the dentist first looks into the parent's mouth, the child may then allow the dentist to look into the child's mouth and check the teeth. The child should not be forced into having the dentist look into the mouth at this "fun visit." The dentist will want

to check the child's teeth every six to twelve months after this first visit. The dentist may recommend a fluoride treatment which is applied to the teeth in the dental office. The fluoride treatment helps prevent dental cavities.

To review, help keep the infant's mouth healthy by 1) feeding upright, 2) wiping off gums and teeth after every feeding, and 3) using fluoride, as prescribed. When the child is 18-24 months of age, help the child 1) brush and floss regularly, 2) eat a well-balanced diet with few sweets, and 3) visit the dentist regularly. Parents can help prevent dental disease in their children.

"The Family Circus" by Bil Keane, Reprinted Courtesy The Register and Tribune Syndicate. Inc.

BIBLIOGRAPHY

American Academy of Pediatrics. Standards of child health care (3rd ed.). Committee on Standards of Child Health Care. Evanston, IL, 1977.

Whaley, L.F. & Wong, D. Nursing care of infants and children. St. Louis, MO: C.V. Mosby Co., 1979.

# 5

# MINOR ILLNESSES AND INJURIES

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Minor illnesses and injuries can perplex the most experienced parents. All the education in the world seems to pale in the face of a child with a fever or with impaired breathing. This section is designed to allay your fears concerning some of the most common illnesses and injuries your child can have from 0-3 years of age and to help you appropriately deal with these maladies.

Your family physician is your best resource. If you have any questions concerning your child's health call immediately. The following are guidelines intended to help you make the observations your doctor will need to help with a diagnosis. In so doing, you become partners with your physician in maintaining your child's health. Always remember, if you have any doubts, see your doctor.

Fever. A normal temperature is 99.6, rectally and 97.4, under the arm. Follow the directions of your doctor concerning which method is preferred. Just keep in mind that before the age of 5 a child cannot hold a thermometer by mouth well enough to get an accurate reading. Whichever method you use, be sure you report the method to your physician when reporting a temperature. If the temperature is above 101 rectally, it is considered abnormal.

Some signals your child may give you that are clues to indicate fever are listlessness, flushed cheeks, hot face and neck, and being overly sleepy. Put your child to bed and take the temperature if you suspect fever. In addition to noting those other signs of fever, your doctor needs to know the temperature reading and method used.

To take a temperature rectally, use a rectal thermometer which has a rounded, stubby bulb. Grease the bulb with some lubricant, such as vaseline, and insert it only to the end of the bulb while holding your child on your lap with the baby's belly against your legs. It will take about three minutes to register an accurate temperature.

To take it from under the arm (axillary), hold your child close to you and press the arm close to baby's side. Then hold the thermometer in place for at least five minutes.

In the 0-3 age group, children tend to run high fevers even with simple colds or sore throats. If, however, your child runs a fever over 104°, it is a warning that your doctor needs to be consulted. Also, if a fever hangs on for more than 36 hours, call your doctor. You need to call your physician also if other symptoms develop, such as vomiting, diarrhea, earache, or breathing problems.

Basically, what you need to know is that fever is an important means by which your body handles infection. Since it is only one sign of infection, it need not be treated vigorously for itself alone in the absence of other symptoms. Babies, especially, have an immature temperature-regulating system and so will often run high fevers with the smallest bit of infection. If there are no other symptoms present, you can try

to control the fever yourself for a short time. Tylenol is very effective for decreasing temperature. Read the label directions and follow accordingly. Call your doctor for a child under one year. Only use the tylenol when you need to for fever. Wait for one to two hours for the medication to work--i.e., the fever to go down. In the meantime, encourage your child to drink lots of clear liquids, such as water, apple juice, and jello water, and use lukewarm (not cold) sponge baths to decrease the temperature. Bear in mind that the most important thing you can do for your child if hot is to keep the child well hydrated. If your child refuses fluids, and he/she may well do so, you may have to force fluids. Try lollipops or popsicles for an older child and jello water for a baby.

After the fever subsides, watch your child for other symptoms such as diarrhea, vomiting, ear pulling, and breathing problems. Call your doctor if these exist. If your child seems to be all right, there may be no need to see a doctor. You know your child best. If you think a visit is in order in the absence of other symptoms, then, by all means, consult your doctor.

Vomiting. This section does not concern the normal spitting up that young babies do after feeding, but, rather, the vomiting that occurs due to some disease. If your child vomits with great force (projectile) or if there's green bile or blood in vomitus or if your child appears to be in pain, then see your doctor.

Vomiting, especially in young infants, can be a signal that a serious condition exists. Vomiting occurs because the stomach is upset by some disease and, therefore, cannot handle food. This being the case, it is best to give the stomach a complete rest by withholding food and fluids. It may, however, just be a symptom of an infection, especially if fever accompanies it. If your child starts vomiting a large amount, take your child's temperature.

Many infections start with vomiting in young children. If there is no fever and your child appears normal and is experiencing no pain, watch the behavior, but there's probably no need for concern. If the vomiting persists, restrict intake of foods and fluids for at least four hours but no more than six hours.

Begin introducing fluids gradually when the vomiting has ceased. Start with a clear liquid diet that consists of such items as water, jello water, gatorade, broth, and de-carbonated beverages. Do not give milk or solid foods for at least 24 hours. If your child tolerates this well, then you can gradually begin a regular diet by introducing bananas, applesauce, and rice cereal. Consult with your doctor concerning the dietary guidelines for your child's individual situation.

Diarrhea and Constipation. Both diarrhea and constipation are common problems that can be related to feeding and can therefore be controlled through some dietary changes. First let's discuss constipation. Constipation is a condition practically unknown in the breast-fed infant who gets adequate milk. It is also rare in the formula fed baby or in young children who have enough food and liquid. Keep in mind that it is the consistency of the stool; and that is, whether it is very hard and dry or normal, and not the frequency that constitutes constipation. In other words, some children can go for up to two days without a bowel movement, but when they do have one it is normal. If, however, your child does suffer from a bout of constipation, simply increase fluids and food, such as cereal, fruits, and vegetables. Avoid the use of laxatives, enemas, and suppositories unless your doctor specifically prescribes their use.

Diarrhea stools are frequent, not well formed (loose), and watery. Their occurrence is sometimes caused by diet and sometimes by viruses and bacteria. A child may also get diarrhea from head colds or other infections. It can occur

when the food your child eats is irritating for some reason or spoiled. It, like constipation, will respond to a dietary treatment. In this case, though, it will be necessary to decrease food and milk intake and replace them with water and clear liquids (refer to vomiting).

When diarrhea occurs, your child's intestines are, for some reason, irritated and, therefore, the body cannot absorb liquid and form stool like they normally do. Food is rushed through without having a chance to be compacted. Nutrients are not being absorbed into your child's system. The result is a loose, watery stool and a child who has not received the proper nutritional benefit from the food eaten. The stools may be green from bile high up in the gastrointestinal tract and should cause no particular concern. It simply means that the stool rapidly sped through the system. If, however, the stools are green, mucousy, and foul smelling, contact your doctor. While this may be a simple case of diarrhea, it is vitally important that you replace the fluids being lost. If there is no response to the clear liquid treatment within 24 hours, call your doctor. Likewise, call if a fever is involved, if your child looks dehydrated (dark circles under the eyes, decreased urination, sunken soft spot, thirst, dryness of the mouth), if the stools become bloody, or if vomiting is present. DO NOT LET DIARRHEA GET OUT OF HAND!

Colic. Colic is a condition in the very young infant that consists of screaming, pulling up of the infant's legs, thrashing, and generally inconsolable activity. It is accompanied by an overactive bowel that leads to gas which leads to pain which leads to more screaming. It is a vicious cycle that is difficult to control and can, unfortunately, last through the first three months of life. It can be caused by nervous and tense parents or simply by feeding technique. Most infants who are inclined to be colicky are hypersensitive to their environment and, hence, to the stimuli around them. Often what happens

is that the baby's fussing will cause the parents to overreact and try numerous ways to comfort the infant which actually result in an over-stimulation. This, in turn, creates more fussing. Fussing increases the air being ingested which will lead to gas and more crying.

What does one do with such a child? If the child is ingesting too much air from an improper feeding technique, then try holding the baby more upright while feeding and, also, burping in the middle of the feeding. If you have altered the feeding technique with no success, then it is time to try one of several techniques to relieve gas pain. Parents of colicky babies will, undoubtedly, have developed a favorite method that they may pass on to you. The following are some of the most popular.

1. Place a hot water bottle or heating pad on baby's tummy. (Be careful of burning the baby's sensitive skin.)
2. Lay baby on the stomach across your lap and gently rock.
3. Place in a small car bed and place the bed on a clothes dryer while it is operating. The warmth and rocking may give baby some relief. Stay with your child.

Above all, try to maintain a stable and quiet environment for the child. Baby senses adult tensions and responds accordingly. Take heart, dear parents, this stage will pass.

Colds. Most colds are caused by viruses and are characterized by congestion, runny nose, fever, and cough. Do not expect your doctor to administer antibiotics for a common cold. Antibiotics are only effective against bacteria and will not work against cold viruses. The cold, therefore, must be treated symptomatically and be allowed to run its course of seven to ten days. The best that you can do is make your child comfortable. Children in the 0-3 age group get an extraordinary number of colds, but it is comfort-

ing to know that their susceptibility decreases as they get older. Treat all colds the first time you notice the symptoms.

Increase your child's fluid intake while decreasing milk and milk products which serve to thicken mucous and saliva. What you want to do is help loosen the thick mucous that is coming from the nose and chest by increasing clear liquids. Food can continue in a regular manner, but do not force food. Elevate the head of the bed to help promote drainage. Keep the room moist through the use of a cool-mist vaporizer or cool-mist humidifier. Promote rest and warmth, but be careful not to overdress. Use cream or vaseline under the nose to prevent soreness. Nose drops made of salt water (one quarter teaspoonful in eight ounces sterile water) can be very effective in shrinking the lining of the nose and keeping the nasal and sinus passages open (refer to Administration of Medications). Do not use nose drops more than every four hours or for more than five days. Refer to section on fever if fever is present. If your child has a temperature over 101°; has breathing problems; pulls at his/her ears; is overly fussy; has thick, foul nasal discharge; has a cough that awakens him/her during the night; or has a sore throat do not hesitate to consult with your doctor.

Ear Aches (Otitis Media). Otitis media is the most common ear infection in young children. It usually occurs secondary to a cold. When a young child has a cold, the nasal passages become blocked with mucous. Since the young child's eustacian tubes (those tubes that drain from the ear; are straight and connect to the nasal passages, they can easily become blocked. This blocked space then becomes a perfect space for the growth of bacteria, resulting in middle ear infection. This condition requires immediate attention. In the young infant, you may notice fever with the cold and the baby may be irritable and rub the ears. You may also notice crying every time the baby is laid down. The older

child will complain of pain, deafness, or popping noises. It is important to seek medical advice so antibiotic therapy can be started because improperly treated ear infections can lead to hearing loss. Once antibiotics are begun, dispense the medicine exactly as prescribed. Even if your child seems much improved, continue giving the medicine for the prescribed length of time. Otherwise, the infection may start up again. NEVER KEEP OLD ANTIBIOTICS AROUND THE HOUSE AND NEVER USE THEM ON ANY OTHER MEMBER OF THE FAMILY.

Croup. Croup is an illness caused by the same viruses that cause colds and flu. It's common in the infant/toddler age group and most prevalent in the fall and winter months. There are a number of different kinds of croup, but in all of them the child has difficulty breathing, is restless, and may be feverish. The "croupy" cough that is characteristic of this disease is a barking cough. The child is usually agitated and frightened. You can help relieve the distress by turning the hot water on in the shower and promoting a moist steam atmosphere in your bathroom. It would be wise, however, for you to take your child to your doctor or the emergency room if your child appears distressed and is getting no relief from the bathroom treatment. Croup can be dangerous and can block the upper airways and needs attention.

Urinary Tract Infections. Urinary tract infections are quite common in the young age group discussed here. Because of the growing kidneys, it is important that these infections be taken care of quickly. Generally speaking, girls are more susceptible than boys simply because of their anatomy. In this age group, most urinary tract infections will be found in two and three year olds. In the very young infant, the symptoms are non-specific. The baby can have fever, diarrhea, vomiting, a decreased feeding, irritability, and failure to thrive. Any of a number of diseases may present these symptoms. The only way, therefore, to know if urinary tract

infection is the cause is to obtain a sterile sample of urine and perform laboratory studies on it to see if bacteria are present. Your doctor will explain to you how to obtain this sample and will provide you with the necessary equipment to do it. The two or three year old child will have a very high fever. The toddler may also have blood in the urine, have strong smelling urine, vomit, and have abdominal pain. Here, too, a sterile urine specimine will be necessary. If bacteria are found to be present in the urine, then a course of antibiotic therapy will be begun. It is important also to encourage fluids to help flush out the urinary tract. When cleaning your daughter's bottom, be sure and clean from front to back to keep from infecting the urethra with bacteria from the rectal area. Encourage this same cleaning method when you are toilet-training your young daughter.

Conjuctivitis (Pinkeye). This is a condition that is caused by bacteria and is extremely contagious. You will most likely notice it when your child awakens with a whitish-yellow crust around the eyes caused by pus. The whites of the eyes will be red or pink in appearance. See your doctor so your child can be started on antibiotic eye drops. (See section on Administration of Medications.) Since the eyes will be irritated, you can offer some relief by putting cool compresses over the affected eyes. Since it is highly contagious, it is important that separate washcloths and towels be used for this child. Scrupulous hand-washing is important as well in preventing affliction of the rest of the family.

Rashes. There are a number of rashes that children seem to get. The ones that will be discussed here are impetigo, heat rash, roseola, and diaper rash.

Impetigo is a contagious skin infection caused by a bacteria. It usually starts on the face and appears as a blister that breaks open and oozes a straw-colored pus that forms a crust

when it dries. The condition is itchy, but the child must be prevented from scratching it or other areas. Other people will be infected from the child's hands. Prompt treatment, however, can clear the condition. If it is neglected, it can lead to other, more serious, conditions, such as heart and kidney problems.

Generally, the treatment requires that the affected area be cleaned regularly and includes oral antibiotics. Consult with your physician immediately if you notice this condition. As with conjuctivitis, precautions must be taken to prevent other family members from being infected. It may take up to two weeks in some cases for the rash to be cleared up.

Diaper rash is caused by the ammonia from urine irritating a child's sensitive skin. There are a number of measures you can follow to help clear up the condition when it happens.

1. Leave the diaper area exposed to air as often as is practical.
2. Expose the diaper area to a 40 watt bulb for 20 minutes. Keep the lamp 12 inches away from baby's skin. Make sure the area is clean, dry skin and be sure to watch the baby the entire time to guard against overexposure. When using this treatment on male babies, keep the child on his belly so as not to expose the penis to the heat.
3. Frequently change diapers. Check them at least every hour.
4. Stop the use of rubber pants and any other clothing that will be tight around the baby's thighs. This will also allow air to circulate to the diaper area.
5. Use a powder, such as cornstarch, on the diaper area. It will help to absorb the ammonia.

6. Before drying cleaned diapers, rinse in an antiammonia rinse, such as vinegar, Borax, or Diaperene, to help neutralize the ammonia.

7. Use a protective ointment like vaseline to protect the diaper area and give it a chance to heal.

8. With the use of disposable diapers, you may find it necessary to change brands or discontinue their use all together. Some babies are sensitive to disposable diapers.

9. It may be necessary to change detergents or to rinse the diapers out more thoroughly after washing. Your baby may be sensitive to the detergent you use.

The problems mentioned in numbers seven and eight are the result of an allergic reaction and not merely contact with ammonia from urine. If none of the measures you try clears the rash, then your baby may have an allergy. Work with your doctor for other treatment methods. If you notice ulcers on your son's penis, this may be the result of ammonia burn and needs to be brought to your doctor's attention. Any scarring that results from an untreated ulcer could potentially lead to a decreased opening at the penis tip (urethral meatus).

Roseola is a condition believed to be caused by a virus that is very common in infants and toddlers. Unfortunately for the parent, the disease isn't really apparent until it has almost run its course. It is then that the characteristic rosy patches appear and a definite diagnosis can be made. The usual course of the disease is as follows. The child will persist with a high fever of 103 to 105. In this case refer to the section on fevers and follow the measures necessary for reducing fever. The fever may stay elevated for three to four days and require around the clock treatment to keep the fever down. Symptoms of an upper respiratory infection may be present, but the outstanding feature of this disease is the initial absence of physical findings. After the fever drops, the rosy patches will appear. You will probably first notice them on your child's chest and face. They will spread later to the arms and legs. These patches will disappear in about two days and your child will be back to normal with the added bonus of permanent immunity to roseola.

Heat rash (prickly heat) is a pimply rash that is the result of blocked sweat glands. Usually, warm weather and overdressing are the main culprits that cause a young baby's sweat glands to work producing sweat. If the pores leading to the glands are blocked then the sweat will be held under the skin, producing a small, raised pimple or bump. There will be no visible sweating. Avoid the use of soap and bathe fre-

quently in cool water. Use a light dusting of powder and calamine lotion on the affected areas. Most especially, avoid overdressing and overheating the house.

Convulsions. A convulsion results when there has been some irritation to the brain -- fever, trauma, poison. The most common cause of convulsion in the infant/toddler group is high fever. Keep in mind that if your child has a convulsion with a high fever, it does not mean that there will be future problems with seizures.

Every child who has a seizure will display different characteristics. Some of the most common signs include rolling of the eyes, jerking of the body, and staring. It is usually a self-limiting activity that will last for only a few minutes. If the convulsion shows no signs of ending, it is important to seek medical attention as soon as possible. In this case certain medications will be needed to help stop the seizure.

Even though the seizure will end by itself in most cases, there are a few things you can do that will benefit your child while the seizure is in progress. Most importantly, be sure that the environment around your child is safe. In other words, help to lay your child flat on a safe surface (bed, floor) where there is no danger of injuring the child's head. Do not restrain the body if jerky movements are displayed. Fractures can develop from restraining a taut and jerky limb. If your child is clenching his/her teeth, do not try to pry them open in order to keep the child from biting the tongue. More damage can be done from this action than from the bite on the tongue. Stay with your child the whole time the seizure is in progress in order to maintain a safe environment and to observe the type of seizure. Keep the head turned to the side as much as possible so that any secretions (saliva, vomitus) that pool in the mouth can run out and be stopped from choking the child. Take careful note of what your child was doing just prior to the onset of the seizure, when the seizure

began, what happened during the seizure, and when the seizure stopped. Your observations will be very beneficial to your doctor. After the convulsion has ceased, your child may be very listless and sleepy. Don't disrupt this sleep, but be sure to contact your doctor right away for further instructions.

Do not attempt to give your child anything by mouth during a seizure or to stop the seizure with a bath. Both of these practices are potentially dangerous.

The fact that your child has had a febrile convulsion does not by itself mean epilepsy, nor does it mean that a convulsion will result every time there is a high fever. In other words, do not worry excessively about this single incident. However, it is essential that your child be evaluated by a physician and that you be aware of what to look for and what to do in case another seizure occurs.

Tear Duct Obstruction. The tear ducts are located at the inner aspect of the eyes right beside the nose. They function like small tunnels to carry the tears from the eyes to the nose. Sometimes the tear duct of one or both eyes is blocked at birth or irritated by the silver nitrate used after delivery. When this happens, a parent may notice increased tearing from the affected eye(s). The eye(s) may also appear to have a film over it and creases in it. The increased tearing is a result of the tear duct's inability to drain the tears to the nose. The tears, therefore, stay in the baby's eye(s). Normal mucous build-up (a reaction to dirt and dust in the eye) also cannot be washed away so the eye(s) begins to develop a film and creases (mucous).

If you suspect a blocked tear duct, massage the tear duct to help open the passage to the nose. Do this three or four times a day. If the condition does not improve, consult your physician. It may be necessary to have the duct probed open. This is a simple procedure. Do not worry that the condition will affect the eye.

Ringworm. This is a fungal infection that is common in young children, especially if they have been around infected domestic animals or infected soil. Characteristically, ringworm displays a red ring that begins as a small, round, red spot that will gradually increase in size. The border of the ring will generally be red, raised, and scaly. Home treatment requires topical medications, such as Tinactin. Ringworm on the scalp will require an oral medication. Consult with your doctor to determine the best course of treatment for this condition.

Scabies. Scabies is a skin irritation caused by a mite. The mite likes to burrow beneath the skin and lay its eggs. Sometimes the burrows can be seen, but usually they are obscured by the redness and swelling that follow after the mite gets under the skin. The child who is infected with scabies will scratch the burrows excessively and increase the irritation to the skin. To control the itching try using cool compresses and calamine lotion on the affected areas. If the irritation shows signs of infection and gets progressively worse, see your doctor. The condition may need to be treated with a prescription medication.

Pinworms. Your child can get pinworms from anything contaminated with infected feces, such as food, soil, or another child. They take up residence in the lower intestine and will look like white threads in your child's stool. At night the females migrate down the intestines and crawl outside to lay their eggs between the buttocks. The most common symptom of this condition is itching around the anus, especially at night. It may disrupt your child's sleep. To diagnose the condition, collect the pinworms with clear cellulose tape. During the night or early morning, place the tape between the buttocks for about one minute. Bring this specimen to your doctor for examination. Your doctor may prescribe an oral medication designed to kill the parasites. If one is prescribed, do not be surprised if it must be given to all family mem-

bers. This will help to decrease the chances of their getting the pinworms also. Help your child to refrain from scratching by washing the anal area frequently. You may also choose to use a spray designed to decrease itching. Encourage scrupulous personal hygiene for all family members.

Nosebleeds. Most nosebleeds are the result of picking the nose. The soft part of the nose becomes irritated from the trauma of being picked and bleeding results. Nosebleeds can also result from the irritation caused by the common cold. Vigorous blowing of the nose will irritate the mucous membranes which are already dry and cracked from the dry air of winter weather, resulting in a nose bleed. The most effective action to take is to pinch the nostrils closed with your thumb and forefinger for at least five minutes while bending the head forward. An ice pack or cold compress placed across the bridge of the nose or back of the neck will help to constrict the blood vessels in the area and decrease the bleeding.

To decrease the incidence of nosebleeds, discourage the chronic nose picker from continuing with the behavior and keep the nails trimmed. If the bleeding is the result of a cold, then treat the symptoms of that cold as outlined in the section on upper respiratory infections and keep your home humidified. If nosebleeds are frequent and not associated with a cold or with injury, see your doctor for further evaluation.

Poisons. Refer to the section on Safety for instructions on the importance of keeping poisonous substances out of the reach of infants and toddlers. Discussion here will center on what to do when your child does manage to ingest some poison.

Prompt treatment is of utmost importance. First call poison control for instructions, initiate treatment at home, then get to the emergency room. Try to keep in your medicine cabinet bottles of Syrup of Ipecac and Milk of Magnesia.

When the poison ingested is composed of acids, alkalis, or petroleum products, then DO NOT INDUCE VOMITING. Products for which you would not want to induce vomiting include liquid furniture polish, kerosene, gasoline, ammonia, drain cleaners, bleach, insect sprays, and cleaning fluids. These chemicals are highly corrosive and can do great damage to the esophagus and lungs if the child is forced to vomit. The best thing to do is to coat the stomach with milk or Milk of Magnesia, thereby neutralizing somewhat the corrosiveness of the ingested material. SEEK MEDICAL TREATMENT IMMEDIATELY!

When the poison is a medication or plant, then give the child one tablespoon of Syrup of Ipecac. This medication will help your child to vomit. If vomiting has not occurred after fifteen minutes, then give a second dose. If you do not have Ipecac, then try to stimulate the back of the throat with your finger or administer a mixture of mustard and water. Collect the vomitus so that you can show it to your doctor or to the emergency room physician. Once again it is important to seek medical attention promptly.

Animal Bites. Any bite by an animal, other than your family pets if they are vaccinated, warrants a visit to your doctor. It will be necessary for your physician to determine if it is necessary to begin antirabies vaccine and to administer a tetanus shot if your child is not already protected.

Try to locate the animal that bit your child and keep a close watch on it for fourteen days to be sure it doesn't develop rabies. In some localities the local health department or animal shelter will take care of this for you. If your child is bitten, call your health department to check on the exact procedure to follow.

Before bringing your child to the doctor, be sure to cleanse the wound thoroughly with soap and water.

A short statement needs to be made here concerning human bites. Human bites can be more dangerous than animal bites because of the danger of infection. Cleanse with soap and water. See your doctor for any bite that breaks the skin.

Cuts, Abrasions, and Puncture Wounds. Any time the skin is broken it is necessary to treat it in order to prevent infection. The skin is a natural barrier against the invasion of bacteria. Any time it is broken, bacteria can get in and cause numerous infection problems.

When the skin is cut, or lacerated, cleanse the area thoroughly with soap and water, getting out all the debris and grit that may be present. Hydrogen peroxide (3%) may be used in addition to the soap and water. If the cut is not very deep, all you may need to do is apply some topical antibiotic ointment (Mycitracin, Bacitracin) and a bandaid or sterile gauze. For a laceration that is minor but needs to have the edges held together, use butterfly bandaids or steri-strips. Apply these so that the edges meet evenly and do not roll inward. If the cut is on the face, see your doctor so the possibilities of scarring can be minimized.

Abrasions are very shallow breaks in the skin that do not go below the skin surface. Once again, clean thoroughly and scrub away the dirt and debris. There is no need for a bandaid or dressing of any sort because the abrasion will form a scab which will act as a natural dressing. If the abrasion begins to ooze, then a dressing may be applied.

Puncture wounds are caused by nails, pins, and other sharp objects. Let the wound bleed as much as possible to aid in cleaning out any dirt. Be sure that the object that caused the wound is completely removed. Wash with soap and water and treat as you would a cut. Check with your doctor to be sure that your child's tetanus immunization is up to date. Tetanus is the most important concern with puncture wounds, so knowing your

child's tetanus status should be of prime consideration. Soak the wound three to four times daily in warm water for four or five days to keep the wound open and draining. This will decrease the likelihood of infection setting in. Unless you are sure you can completely remove the foreign body, it is best to let a physician treat this kind of wound.

You will know if infection has begun in a wound if you detect an increase in redness, increased swelling, drainage of pus, foul smell, red streaks radiating from the wound, or the area feels very warm. To treat the infection, soak the wound in warm water for a few minutes daily for three or four days. This will help to cleanse the area of any debris and keep the scab soft. If no improvement is noted or if fever develops, see your doctor.

Burns. Burns can be a serious problem depending on the type of burn received. There are three types of burns. First degree burns are very superficial. They result in a reddening of the affected skin and do not usually require the intervention of a physician. This type of burn can be very painful, however, and can be helped somewhat by the use of cold water. The cold will help to reduce the skin damage and decrease the pain. No dressing is needed unless the area is constantly being chafed by clothing.

Second degree burns affect deeper layers of the skin and will cause blistering. DO NOT DISRUPT THE BLISTER. It is a natural bandage and will help to guard against infection. If the burn covers a very small area, then you may be able to treat it at home using light gauze dressings. However, if the burn covers a large area or is located on the face or hands, then see your physician for treatment.

Third degree burns affect all the layers of the skin in addition to some muscle and sometimes bone. These burns are painless and will cause charring of the skin. They are painless because the nerve endings that send pain signals to the

brain are also burned. A doctor must be consulted for this type of burn because of the life-threatening potential of the injury. Cover the area with a clean cloth that has been soaked in cold water. Your object is to reduce as much fluid loss as possible and to protect the area from dirt. Remember, the body's protective barrier has been burned away and must be replaced with an artificial covering until medical assistance is received.

Broken Bones. Without an X-ray there is no way to tell if a bone is broken unless it is poking through the skin. If a limb has been injured, immediately apply ice packs to reduce swelling and inflammation. Rest the affected limb by immobilizing it above and below the nearest joint. Note if the limb is cold, blue, or numb. Because a young child's bones are still growing, all bone injuries should be seen by a physician. Any suspected fractures of the thigh or pelvis are emergencies.

Head Injury. Head injuries are all potentially serious and, therefore, must be treated accordingly. Infants and toddlers seem to sustain quite a few of these injuries from falling out of their high chairs and cribs and bumping into furniture. Most of them develop into the familiar "goose egg" bump without any other symptoms. However, parents must be on the alert for potential problems. Any loss of consciousness must be considered an emergency.

The major concern is for bleeding into the skull. Since we cannot see into the skull to see if bleading is present, we must rely on other signs. If your child has sustained a bump on the head, put ice on the bump immediately to keep the swelling down and then observe for the presence of the following signs -- persistent vomiting, alternating periods of drowsiness and alertness, pale skin, sweating, slow pulse of less than sixty, unequal pupil size, weakness, difficulty in arousing, changes in behavior patterns, headache, convulsions, and dizziness. If your child

is sleepy but arousable and vomits only once or twice, then he/she will probably be back to normal by the next day. If any of the other signs are present or if your child was knocked unconscious, then see your doctor for further evaluation.

Administration of Medications. Administering medication to your child can be a discouraging and frustrating venture. When giving medicine to a young child it is very important that the proper amount be given lest an over- or underdose be given. It would be wise, therefore, to invest in a measuring instrument to dispense medication to your child accurately.

Nurses have found that the easiest way to give an infant oral medications is to use a 10 cc. syringe (without the needle). Measure the prescribed amount into the syringe and insert the tip of the syringe into the side of the infant's mouth while injecting small amounts of the medicine. You may find that your infant likes the medicine and swallows it willingly. On the other hand, the child may try to spit it out. It is important, therefore, to try and squirt the medicine into the back of the throat.

For a child who can take a spoon, you should be able to purchase a measuring spoon at your local druggist that is designed to measure and dispense the medicine. A syringe can also be used for the toddler, who may actually prefer it.

Whatever method you use, it is important to give medicine with a matter-of-fact attitude, as if you expect the child to take the medicine without a hassle. Stand firm. It is important for your child to be receiving medicine in order to regain health.

To administer nose drops properly, it will be necessary to have your child lie on a bed with the head hanging over the side, face up. Suck out any mucous in front of the nose with a nasal syringe before putting the drops in. After inserting the drops into each nostril, keep your

child in this position for about thirty seconds. This will allow the drops time to work into the upper passages of the nose.

To instill eye drops in a child's eyes, hold the child's head firmly and steadily with nose pointing toward the ceiling. Spread the eyelids open using your thumb and forefinger and let the medication drops fall on the part of the eye closest to the nose (inner canthus). When you release your fingers, the child will blink and the drops will enter the entire eye area.

To apply eye ointments, merely apply a small amount to the inside of the lower lid by squeezing it out from the tube. Remove the excess with a tissue or gauze.

When instilling ear drops, have the child lie down with the ear to be treated pointing to the ceiling. Grasp the upper part of the ear lobe (pinna) and pull it gently down and back to straighten the ear canal. Administer the proper number of drops, then instruct the child to maintain this position for a few minutes to give the medicine a chance to reach the affected area.

Adverse Reactions. If ever you notice a rash develop anywhere on your child's body after giving a medication, stop the medicine and consult with your doctor. Likewise, if your child has difficulty breathing, wheezes, or turns blue, get to a medical facility immediately. This could be a violent allergic reaction to a medication, food, plant, almost anything. Medical treatment is needed immediately. If an agent is identified that has caused this reaction, then be very careful that your child does not come in contact with it again. If a medication caused the reaction, always be sure that the doctor and nurses who care for your child in the future are aware of the allergy.

Summary. Caring for a sick or injured child need not be an awesome task. It is hoped that the guidelines included in this chapter will help

you to provide your child with the best care possible in a relaxed atmosphere free of the tensions that often haunt an uninformed parent.

BIBLIOGRAPHY

Arena, J. M., & Bachar, M. Child safety is no accident--a parent's handbook of emergencies. Durham, NC: Duke University Press, 1978.

Brazelton, T. B. Infants and mothers--differences in development. New York, NY: Delta Books, 1969.

Pantell, R. H., Fries, J. F., & Vickrey, D. M. Taking care of your child--a parent's guide to medical care. Reading, MA: Addison-Wesley, 1977.

Scipien, G. M., Barnard, M. U., Chard, M. A., Howe, J., & Phillips, P. J. Comprehensive pediatric nursing. New York, NY: McGraw-Hill, 1975.

Smith, L. M. The children's doctor. Englewood Cliffs, NJ: Prentice-Hall, 1976.

Smith, L. M. Improving your child's behavior chemistry, a new way to raise happier children into healthier adults. Englewood Cliffs, NJ: Prentice Hall, 1976.

Spock, B. Baby and child care. New York, NY: Pocket Books, 1976.

Stann, J. H. "Urinary tract infections in children." Pediatric Nursing, July/Aug., 1979.

Vaughan, V. C., McKay, R. J., Behrman, R. E. Nelson-textbook of pediatrics (11th ed.). Philadelphia, PA: W. B. Saunders Co., 1979.

# 6

# MINOR HOSPITALIZATION

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Hospitalization is not something that most parents prepare for when they have a baby. Understanding some of the reasons why a child might need to be hospitalized, the experience, if it should occur, may be less upsetting for you, your child, and the rest of the family. Many hospitalizations are for accidents and common childhood illnesses that children experience difficulty recovering from at home. Other children are admitted for more serious and chronic illnesses. Hospitalization allows the physician to run tests to exclude any serious illnesses. The hospital provides a nursing staff to give medications you would not be able to give at home. They also observe your infant or toddler to help the doctor diagnose any unusual problems.

## Admission Procedures

Patients are generally admitted to the hospital from their doctor's office or the Emergency Room. Regardless of which route brings you to the hospital you are faced with admission paperwork before you find yourself on the pediatric floor with your child.

In the Emergency Room you will be asked to sign a consent form for all emergency treatment. Anything that can be handled at a later time will require additional consent. Special involved procedures and operations require your specific consent and cannot be done without it.

In Admitting you will be asked to sign a consent form that covers routine hospital procedures. Admitting will also ask your name, your child's name, address, phone number, place of employment and insurance information, i.e., Blue Cross/Blue Shield policy number, Major Medical number, or ask to see your Medicare or Medicaid card. If it is an emergency admission and you do not have this information with you, you should arrange to bring it to the admissions office as soon as possible.

You must be the child's legal guardian to sign hospital consent forms. If you are not the legal guardian let the hospital know where that person can be reached. Read all consent forms carefully and ask questions when you do not understand. If you are divorced and the other parent will be paying the bills let the hospital know. If you do not have insurance, the hospital, at your request, will refer you to their Financial Aide Counselor. This person will help secure funding for your child's hospitalization through various sources or help set up a payment schedule that can be met with your family's budget.

## Hospital Organization

There will be many people examining and caring for your child once the hospital admission process is completed. The personnel can be confusing, and you will find that white uniforms do not always mean doctors.

If hospitalized at a medical center your child will be assigned a Pediatric Intern. This is a doctor who has completed four years of medical school and is doing his first year of training. He is supervised by a Pediatric Resident, a doctor doing his second year of training, and your own physician, also called the Attending. If you are admitted to a non-teaching, community hospital by your private physician he will be your only doctor.

The Charge Nurse or Head Nurse is responsible for the organization of the floor. Working with her are several types of nurses. The Nurses' Aide usually has no formalized training and is responsible for odd jobs on the floor, transporting patients to different departments, bringing specimens to the lab, and routine patient care, i.e., temperatures, baths, changing beds and feeding babies. The Licensed Practical Nurse, or L.P.N., has had a year of formal training and must pass a licensing exam. Depending upon the hospital, the L.P.N. may be passing medications or providing more involved patient care, i.e., changing dress-

ings. The Registered Nurse, or R.N., has from two to four years of formal education and must also pass a licensing exam. An R.N. is responsible for assessing your baby's condition, contacting the physician for new orders or a change in orders, coordinating all the health care professionals who will be involved in the care of your baby, health teaching and discharge planning. In some hospitals the R.N. is responsible for total patient care including everything from baths and medication to calling your doctor for special problems.

Depending upon your child's condition and your family's personal needs, you may also be involved with X-ray Technicians, Inhalation or Respiratory Therapy, Social Service Worker, Financial Aide Counselor or a Physical Therapist.

## Directing Your Concerns

While your child is in the hospital find out who is responsible for his or her care each shift. There will be one person with that responsibility. If you have any questions or problems direct them to this person. If you need help caring for your child ask this person. If you do not understand why your child has been hospitalized or what the doctor plans to do, or if you feel there is any change in your child's condition, then talk to the R.N. The R.N. has the authority to change your child's plan of care, implement the necessary treatment, or contact your physician.

Nurses need to know what your questions, problems, and concerns are in order to best care for your child. Do not be afraid to let them know when you are dissatisfied with something. Nurses need all the information you can give them to provide high quality care for your child. Directing your concerns to the proper hospital personnel can put you in contact with a variety of services that will help with the future needs of your hospitalized child, the needs of your family, or your own personal needs.

## Preparing Your Child for Hospitalization

Regardless of whether the hospitalization is planned or unexpected, the most important thing you can do is support your child emotionally. In the emergency situation tell your child where you are going and why. Acting calm and in control helps make your child feel secure. Find out from the doctors and nurses what they are going to do and elicit their help in explaining things to your child.

For routine hospital admissions you may want to consult books about going to the hospital. Some toy companies make nurse and doctor kits that will help familiarize your child with some of the equipment they will come in contact with.

Play with your child and invite questions that will help alleviate anxiety. Show and touch body parts for explanations. Be honest with your child about pain. Explain that nurses have medicine that will make the pain feel better. Do not threaten your child with mistruths. Never threaten your child with a shot for misbehavior. A shot is not punishment and should not be associated as such. A shot contains medicine to help your child get well.

Nurses and doctors are there to help your child recover as quickly as possible. Your positive attitude and cooperation with the staff will promote a similar cooperative attitude from your child.

Some hospitals have special programs to introduce your child to the hospital and take them on tour. Call your local hospital and inquire.

## Emotional Needs

Infants and toddlers are very dependent upon you and need a familiar person in times of crisis. Starting at about five months of age, when the infant is old enough to recognize strangers, no one can fill this void. Nurses will be able to

provide for your child's physical needs, but can only attend to emotional needs, i.e., extra holding and cuddling, when time permits.

Most hospitals recognize the child's emotional needs and provide a place for at least one parent to stay with the child at all times. If you are unable to stay, try to arrange for a familiar person to stay in your place. If you are not able to stay, do not try to sneak away while your child is asleep. Tell your child where you are going and when you expect to be back. Give your child a specific time, i.e., "When you finish breakfast." Then, by all means, try to be on time. Leaving a familiar object of yours behind reassures the child that you will return. Be sure to let the staff know when you will be back and where you can be reached. The staff can reassure your child while you are gone that you will be back.

Don't be surprised if, upon your return to the hospital, your child ignores you and will not allow holding and cuddling. This is your child's way of showing hurt and disappointment at being left alone. This behavior is normal and is also designed to make you feel guilty. This behavior does not mean that your child does not love you, nor does it mean that your child does not need you or want you to visit. Do not feel obligated to stay with your child 24 hours if you have legitimate responsibilities elsewhere. Do try to change your plans or provide a substitute.

Children often develop a special attachment to a particular blanket or toy. This in itself provides a certain sense of security. Be sure to bring this object to the hospital.

Expect your child to regress to previous behaviors while in the hospital. The three-year-old who was toilet trained may resume bedwetting. Some one- and two-year-olds may revert to the bottle. Accept this behavior during their hospitalization and begin the retraining process after you are home.

Despite the fact that your child is sick, limits still need to be set and discipline provided. Reward your child with praise for good behavior. Act proud. On the other hand, let your child know when you disapprove. Crying is acceptable behavior for fear or pain. Hitting, biting, and throwing things is not. A better way to express anger is with therapeutic play. Spitting out medicine is also not acceptable behavior, and you should not allow this. Your child cannot get well unless the medicine is ingested. Children want to behave in a way that will win your attention and approval. You must help them to do this.

## Therapeutic Play

Make a sock doll for your child to bring to the hospital. Allow your child to be the doctor or nurse and practice on the sock doll. The doll can be your child's "special hospital friend."

Therapeutic Play becomes even more important while your child is hospitalized. It allows your child to alleviate frustrations and act out feelings. Upsetting procedures, such as infections, drawing blood, or starting I.V.'S can all be practiced on the sock doll. Most hospitals allow children to experiment with syringes that have the needle removed. Most nurses will give out double bandaids, too.

A good means for venting anger is with a hammer and peg board or throwing bean bags. The child is then able to alleviate frustrations in a socially acceptable manner.

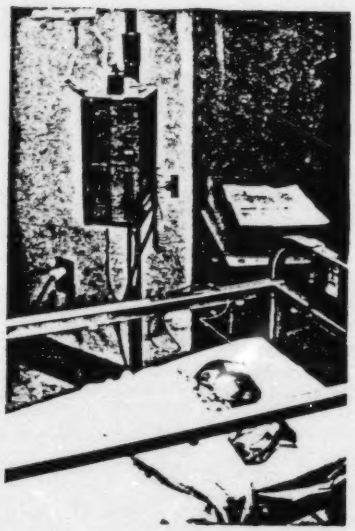
When feeling better it is important to keep your child occupied just as you would at home. Coloring books, crayons, clay, storytime, and a stroll in the wheelchair all help to pass the time. If your child is too sick to go to the playroom some hospitals have volunteers that bring the playroom to the child.

Hospital Procedures and Equipment

Routine Procedures. When you arrive on the Pediatric Floor the nurse will obtain a height and weight and take your child's temperature, pulse, and respirations. The nurse will ask about your child's past medical history, medications taken recently, and any allergies. Do not withhold any information from the nurses no matter how minor it might seem. Doctors have many patients and do not remember everything about each child. The nurse can be instrumental in piecing together information that can be valuable in the diagnosis and treatment of your child. Also give the nurse information regarding any special techniques you use to feed your child or put him to sleep, and the words you use for urine, B.M.'s, milk, bottle, and blanket.

In most hospitals when your child is admitted a chest X-ray will be done, a CBC (bloodcount) and any other bloodwork ordered by the physician will be drawn, and a urinalysis (urine specimen) will be obtained. These tests will be done whether your child is being admitted for surgery or an illness.

Intravenous (I.V.). If your child has pneumonia, vomiting, diarrhea, or an elevated temperature for an extended period of time the physician may order an I.V. This is a small needle inserted into a vein in the head, hand, or foot, depending upon the child's age. The needle is taped into place, the limb immobilized, and the hub of the needle is connected to a sterile plastic tube with a bottle containing glucose (sugar) water and electrolytes. The I.V. provides extra fluid that the body needs during illness and also provides a direct route to give antibiotics so they can act quickly. The I.V. is a way to give large doses of medicine without having to give your child a shot every four to six hours.



I.V. Monitor. This is a machine that is connected to the I.V. tubing. It counts the number of drops per minute that the fluid is running. It is only an aid to assist the nurses to make sure your child does not receive too much or too little fluid. If it alarms, this is a signal that, for some reason, the drip rate is incorrect. It does not mean there is something wrong with your child. Not all I.V.'s will be connected to a monitor.

Injections. Injections, or shots, in the hospital are given intravenous (I.V.) or intramuscular (I.M.). I.V. is usually put in the I.V. bag or bottle. In the child under three I.M. injections should be given in the right or left thigh muscles of the leg. Injections in this age category should not be given in the buttocks.

Spinal Tap or Lumbar Puncture (L.P.). If your child has a very high temperature the doctor may perform an L.P. With the child lying on the right or left side, the doctor inserts a needle into the spaces between the spinal column and withdraws a small amount of spinal fluid. The fluid is sent to the lab to check for bacteria causing meningitis. The skin around the site is

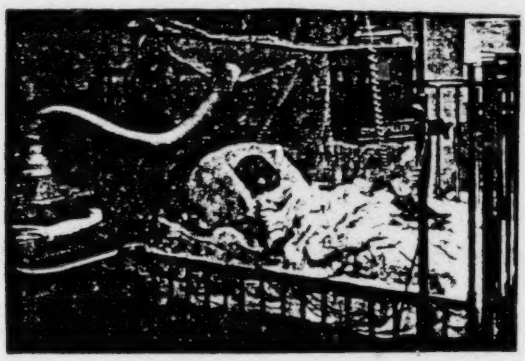
numbed with medication before the needle is inserted. The test takes several minutes to perform and side effects are uncommon. The child under three, unlike the adult, does not have to remain flat in bed after the procedure, but should rest quietly in bed or your arms for several hours.

Oxygen or Croup Tent. If your child is admitted with asthma, croup, or pneumonia you will encounter several types of apparatus depending upon your doctor's choice of therapy.

The croup tent provides high mist concentration mixed with room air or oxygen. This cool, humidified environment helps liquify mucous secretions that build up and cause respiratory difficutly. The oxygen helps your child breathe easier and prevents cyanosis (turning blue).

Encouraging your child to drink lots of fluids also helps liquify these secretions, but a child with severe respiratory distress will be unable to cooperate. This type child will require an I.V., oxygen, and I.V. medications to ease the distress. Metal toys, call lights, phones, or any objects which may cause friction should not be allowed under the croup tent.

Intermittent Positive Pressure Breather (I.P.P.B.). Some doctors prefer to use I.P.P.B. to treat pneumonia, asthma, and croup. I.P.P.B. is a type of respiratory treatment administered by a Respiratory Therapist or an R.N. I.P.P.B. provides air or oxygen under increased pressure during inspiration. It forces the air that is sometimes mixed with medications called bronchodilators into the lungs. This helps your child's



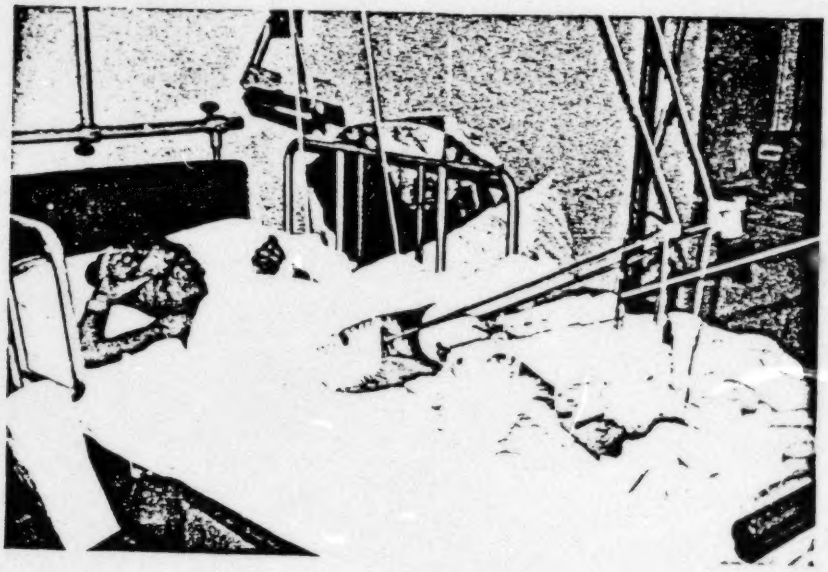
lungs expand to full capacity to receive more oxygen, relieve bronchial spasms and liquify mucus secretions so they may be coughed up.

Ultrasonic Nebulizor (USN). This is a method of utilizing high frequency sound waves to break up the bronchodilating drugs into minute particles that will travel further into the lungs with the force of the compressed air or oxygen. A cool mist vapor is produced that accomplishes similar results as I.P.P.B., but allows the drugs to reach the lower portion of the respiratory tract as well.

Postural Drainage and Percussion. This is a method where your child is placed alternately on abdomen, sides, and back with the head and body in a downward incline position. The Respiratory Therapist or R.N. cups their hands and claps on the child's back to loosen up secretions in the lungs. The secretions then move up the

bronchial tree and can be coughed up. This procedure sounds loud, but it does not hurt. Postural drainage is used in combination with the above mentioned respiratory treatments.

Traction. If your child has a fracture that requires hospitalization traction may be involved. Despite the appearance of the apparatus, it is basically a system of weights and pullies to keep the bone and skin in good alignment while the fracture heals. It is not the traction that causes pain, but the broken limb. Once the limb



is in good alignment the pain usually subsides in 24 - 48 hours. Don't be afraid to have your child medicated for pain. The first 48 hours can be uncomfortable, but after that don't assume your child is in pain because of the traction. Once the limb is aligned, most children need little more than tylenol to keep them comfortable. These children need diversional activities and tend to move freely in bed, traction and all.

Electroencephalogram (E.E.G.). If your child has a convulsion your doctor may order an E.E.G. This is a tracing of the brain's electrical pulses. It is used to diagnose convulsive disorders such as epilepsy. The test is done by putting glue over various areas of the scalp and attaching wires to the glue that run to the E.E.G. machine. The child must lie quietly while the tracing is done. Infants and toddlers are usually given a sedative so the child sleeps through the procedure. The test does not hurt at all. The electrical tracing is read by a trained physician.

Surgery. So, you know that your child will be admitted for minor surgery. What should you do? An honest approach about what is going to happen to your child, regardless of age, helps the child accept hospitalization better. You should explain to the best of your ability and in simple language what will be done, why, and tell your child about the hospital. In the one- to three-year-old age group the night before they are admitted is soon enough.

For all surgical procedures your child will not be allowed to have anything to eat or drink from midnight the evening before, unless otherwise specified by your doctor. In some cases your child may be allowed a glass of juice at 6:00 a.m. Make sure you are aware of what your child is allowed. If food is taken when it is not permitted surgery will be cancelled.

One hour before the scheduled surgical time your child will receive an injection of medication in the thigh. Your child needs to be told that a shot will be given. Children need time to work through anxiety and also need to know that everyone is being honest in their approach. Do not expect the injection to put your child to sleep. It may make your child drowsy, may dry up the secretions in the nose and mouth, may cause thirst, and may cause flushing of the skin.

Your child will ride on a cart to the Operating Room (O.R.). In most hospitals you will be allowed to ride on the elevator with your child, but you will not be allowed to go into the O.R. or the Recovery Room. Find out where you should wait while your child is in surgery.

Be sure to tell your child that the doctor will put him in a special sleep where nothing will hurt. Your child needs to be told that waking up will be done in a special room (R.R.) with special nurses. Explain that you will not be there, but once awake these special nurses will reunite you on the Pediatric Floor. Be honest about pain after surgery. The nurses have medicine to make the hurt go away. If everything happens to your child as you said it would and there are no major surprises, your child will be more accepting, trusting, and adapt better to hospitalization.

The following gives some examples of what to tell young children about some of the usual procedures they are admitted for.

Hernia and Hydrocele Repair: Show the child the hernia or hydrocele. Explain that the doctor will fix the lump so it does not pop out anymore. Make certain your child understands that the hernia will be fixed, not the testicles or penis. A bandaid will be there after surgery for a few days.

Tonsils and Adenoids: Explain that tonsils are in the back of the throat. Tonsils are what get sore and cause sickness. The doctor will fix the tonsils and then the sore throats will not come so often. After the operation the throat will be very sore, but the nurse has medicine to make it feel better.

Myringotomy with Tubes: Explain that the doctor will put little tiny tubes in the ears to prevent so many earaches. Tell your child that after surgery cotton balls will be in the ears and they can be taken out at home.

Cystoscopy: Explain that the doctor, while the child is asleep, is going to take a very tiny light and look up the hole where the urine comes out. (Use the word you normally use for urine.) The doctor will find out why it hurts when the child goes to the bathroom.

## Reassuring Other Family Members

If there are siblings at home be sure to keep them informed. Be honest in your approach and tell siblings how their brother or sister is doing. Try to divide your time as much as possible so they do not feel neglected. Leave siblings with a familiar, trusted person. Allow a feeling of involvement by having siblings prepare cards and special gifts for the hospitalized child. If possible, allow phone calls to the hospital.

Each hospital's visiting rules are different. For the infant too many visitors is tiring and frightening. Only those people who are very familiar to the child should visit, i.e., parents, grandparents, and siblings, when permitted. Keep other family members informed, but let them know kindly that you prefer they visit after you return home.

## Back Home

Before your child is discharged make sure you understand any special instructions regarding activity, diet, or surgical incisions. Be aware of medication dosage and schedule. Be sure medicine is given as prescribed. Not finishing the required amount can lead to a recurrence of the same infection. Follow-up doctor visits are also important to prevent recurrence of problems and to make sure recovery is progressing properly.

Encourage your child to verbalize and act out the hospital experience through therapeutic play at home. Help your child understand what happened and dispel any misconceptions.

Some children have problems after hospitalization, such as over dependence upon their parents, refusal to stay with a sitter (even one who is very familiar), and bedwetting. Be understanding and patient. Ease your child into new situations gradually. If this behavior persists for an undue length of time in comparison to the length and reason for hospitalization, then see your doctor. Your child needs time to be dependent and then a firm stand must be taken.

## Conclusion

Hospitalization is never a pleasant experience, but, with good communication, a knowledgeable approach, and co-operative attitude, it can be a rewarding and educational experience for everyone involved.

BIBLIOGRAPHY

Blake, F.G. Nursing care of children. Philadelphia, PA: Lippincott, 1976.

Brunner & Suddarth. The Lippincott manual of nursing practice. Philadelphia, PA: Lippincott, 1974.

Fuerst, Wolf & Wertzel. Fundamentals of nursing. Philadelphia, PA: Lippincott, 1974.

Hamilton. Basic pediatric nursing. St. Louis, MO: C.V. Mosby Co., 1978.

Marlow. Textbook of pediatric nursing. Philadelphia, PA: W.B. Saunders Co., 1977.

# 7

# THE POWER STRUGGLES

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**D**iscipline begins in those first moments: with the first look you give your infant, with the first moment you hold your infant, and with the first words you say to your new baby. Your first welcome generates a message that states love and security or hostility and rejection to that newborn. Both parents need to endeavor to send intimate caring signals in their first communication with the new arrival. This creative moment of greeting each other deserves as much planning as did the demands of the pregnancy.

Discipline is easiest when the child is seen as a learner. Rules are necessary for living together as a family, for playing with peers, and for being with other adults. To guide a young child during his developmental stages to accept the rules appropriate for the child's age is important for the child's mental health. Recognizing the importance for limit-setting from birth is also important to the parents' mental health.

A disciplinarian who respects human life from infancy a) consistently requires of the child only what is age-appropriate behavior; b) consistently repeats the directions until the child has understood and is able to perform the desired behavior; and c) consistently recognizes that the child is continually in the process of learning. The disciplinarian readily acknowledges "I am an adult with mastery of many understandings. My baby is a learner--only a baby--a vulnerable, dependent, helpless human life. My baby will mirror my attitudes, my beliefs, and my behaviors."

A child who is expected to always set the glass down without spills at the dinner table when eighteen months is already programmed for failure. Calmly wiping the spill, however, is accepting the child as a toddler. Again demonstrating that the glass can be carefully set on the table is a role of instructor. Punishing the child for the spill only teaches the child that the environment is hostile and that he is not fairing well in his emotional space.

Communication occurs when two or more persons exchange thoughts or feelings. Communication requires body gestures or oral language. Sharing information, expressing appreciation, and requesting compliance are our most frequent needs for communicating. Discipline in its healthiest form is communicative guidance.

The active communication between parent and child that is the threshold for positive and effective guidance begins at birth. Fathers who spent time holding, rocking, looking at baby, and telling baby the miracles of having the baby will more likely continue to participate in other parts of the day. Fathers find it rewarding to be involved in bedtime and storytelling, in short runs on errands with baby, and in explaining to baby how a repair job is being done. Wise mothers sing nursery rhymes, move the child from room to room and include baby in their work. They see these shared moments as the groundwork for developing trust and mutual respect.

## Parenting Approaches

Parents approach the way they get children to "behave" in different ways. This individual approach is recognized as the parents' method of teaching or guiding their children. Basically there are three (3) approaches:

1) democratic
2) autocratic
3) rejection.

Parents exhibit behaviors representative of all three approaches. Generally their child-rearing practices more consistently resembles one predominate theme or approach. Holding, rocking, placing baby in an appropriate setting are warm loving ways of relating to your baby.

The democratic parent talks to the child. The situation is explained to the child. A parent of an infant or toddler talks and models the gentle way one strokes a friendly pet. Like-

wise, an older infant is shown how to crawl down the steps. In neither case does the parent presume that the behavior has been learned because it has once been told to the child. Rather, the parent continues to model stroking the animal and verbalizing the behavior being demonstrated. The parent using the democratic approach expands the communication through explaining how the child can expect the pet to respond to stroking.

This parent does not assume that the child remembers from the previous situation though it may be identical. The situation is talked through and the parent supervises to help the child successfully accomplish the behavior expected of him. Behavior that is expected of the child should be developmentally appropriate. To expect an infant or toddler to share toys with visiting toddlers or older children would be unrealistic. The parent can be assured that much can be taught about sharing if the adult stays to supervise, to demonstrate, and to verbally reinforce the desired sharing behavior.

Valuables and irreplaceable items are judiciously removed. This parent is not embarrassed to ask the hostess to place expensive items out of reach during a visit. Early the child begins to be told that items belong to someone other than self. Structuring the environment into "yours" (using baby's name) or "Mommy's" encourages the beginnings for developing respect. Left unsupervised, the infant and toddler are unable to control their spontaneous see-touch-action stage that supplies continual information about their environment. Told "This is Mommy's drawer" the child begins to differentiate the ownership of materials. Provided a "This is baby's drawer" allows the infant/toddler to early learn that life has choices.

This parent is not permissively allowing the child to destroy everything in sight or for that matter anything that the parent treasures. This approach, however, feeds the infant and toddler labels for things. It demands that the

parent work with the child in a variety of settings. It promotes the basic feelings of trust and security. Self-worth and self-confidence grow from knowing "I can act appropriately because I have the skills, I have been told what is expected, and I will be supervised." The child reared in this environment learns to assess a situation and at an older age functions well academically and socially. This parent states what is wanted or not wanted from the child in an "I" message: "I do not want the newspaper hit while I am reading."

Children have fewer risks for failure in meeting the expectations of parents and other adults when they have parents that respect their developmental abilities and stay around to supervise when their management capability will be tested. Children reared in this environment learn to assess a situation and at an older age function well academically and socially.

The autocratic parent dictates behavior . The child must perform the behavior described by the parent. Usually the desired behavior is unrealistic and beyond the ability level of the child. Frequently toddlers are expected to sit through an entire church service or other public meeting without wiggling or talking. Staying clean, using good manners at the table, staying in the yard, sharing toys and establishing early bladder control are just a few of the themes that are focused on by autocratic parents.

Children are spanked, slapped, pinched, bitten, and abused in a variety of other ways. The child who fears his parents' response to errors becomes withdrawn and anxious. The anxiety is frequently expressed in "acting-out" behavior. This child is insecure and doubts his own worth. It is predictable that this child later will be found experiencing scholastic and social difficulties.

The rejecting parent is usually experiencing depreciating feelings about self. This parent often feels insecure and incapable of making an impact on their own adult environment. The ad-

ditional demands of creating a warm, caring, stable condition for a baby exceeds the adult's capabilities. This parent needs much counseling.

Provided the child is a message of confusion. Though the toddler is given the freedom to get his own cereal in the morning from the cereal box he predictably encounters yelling, slapping, or spanking from the mess he made. The infant reaps multiple dental caries from undisciplined provision of a bottle to nurse on when wanted. This carrying around of a bottle is frequently extended to the much older toddler. Regardless of the latitude given for behavior the child experiences hostility, neglect, rejection.

A rejected child frequently has language difficulties as well as socially deviant behavior. From the group of children whose first teachers (parents) were permissive in setting goals for behavior and rejecting of the child and his performance come our school drop-outs and juvenile delinquents.

Rare-use-of-reward and rare-use-of-physical punishment get the most lasting results. In other words, seldom give your child a pay-off for behavior. (Pay-offs come in negative as well as positive responses.) Instead of aversive discipline or rewarding age-appropriate behaviors, focus in on that child, ask questions about his behavior or product that pleased you. Regardless of how young, wait for some type of response from the child. If talking to the very young infant, hold the baby's head in your hands and talk face-to-face to baby. Then wait for baby's answer. Repeat. This type of interaction behavior costs parents time from their other adult hobbies. Your presence lets the child know you care. In reality it is the nicest kind of reward.

Promote children's independence. Encourage even the youngest to think of ways to work out the solution. Tolerate the crying of the infant who has forgotten how to turn around and crawl down the steps and talk him through the necessary

sequence of steps. Similarly, as toddlers out grow the space they used to fit in, talk them through the problem of removing themselves. Your presence encourages the trying and your voice calms the emotions.

Parents need to communicate with each other in order for there to be an agreed-on set of priorities or rules. This is a part of discipline that sustains order when one or the other parent is away from home. It also demonstrates your love and respect for each other which strenghtens continuing communication and respect from the children as they go through the school-age years.

Father-absence is particularly handicapping in rule-setting for boys. The absence of limit-setting by the competent male parent has contributed greatly to inappropriate social behavior and to a higher crime rate for males. The older the male the greater the difficulty a mother alone has raising her children.

In summary, parents of infants and toddlers assume all responsibility for their children's behavior. This requires the parent to recognize the infant's inability to know right from wrong and to therefore carefully supervise the environment and the choices available for action.

## Predictable Power Struggles

Even the most child-oriented parents see behaviors by their children that create tension and eventually become problematic to the parent-child relationship. Ironically, these pressures are intensified by incidents from one's own childhood or by the comments of one's relatives or friends. The following information may help ease some of these frequent no-win scenes.

Crying. The first six months truly test new parents. It seems that much of baby's wakeful minutes are absorbed with crying. Careful observation, investigative skill, and a trial-and-error effort are employed by new parents to find the source of baby's discomfort. Many babies particularly experience discomfort in the late afternoon. This crying is expected behavior. The energy required to respond to the frequent crying leaves new parents exhausted.

Excessive crying that continues after the first six or seven months should be brought to the attention of the physician. Babies should be able to be awake longer periods of time, find enjoyment in grasping and releasing objects, in transferring objects from one hand to another, in sitting, and possibly in crawling.

Baby's crying that is responded to in the first five seconds during infancy is generally followed by decreased crying. Cooing to baby, touching, and rocking reassure baby that he is not alone. Attending to baby's cry immediately lets your baby know that he already is making an impact on the persons around him.

Babies who are entertained every minute become dependent on the parent for putting their sphere of perception into motion. These babies cry anytime left to manipulate the setting alone. If this type crying is occurring, pick your baby up and initiate activity when the crying is subsiding. Be careful, however, not to interrupt baby when involved in some visual attending or motor exploration.

Frequent whining and crying as a toddler that is not related to an accident may be receiving reinforcement (either positive or negative) from parents. If it seems excessive, record when the crying occurs. Look for a pattern. Break the cycle by putting the reinforcement where the baby's behavior most closely approximates that behavior desired.

Because of extensive medical problems, Ryan had been held for most of six months by his parents. Even when the problem was corrected, according to the pediatrician, Ryan's parents were unable to let Ryan assume an active, normal infant life. Ryan dictated the emotional environment. There was tyranny unless he was being held. Gradually the parents learned to set Ryan down to play (whereupon he immediately began to cry) and to initiate manipulation of the toys and to wait for the first quiet tones in Ryan's crying. They would then pick him up, continue to play with the toys, and then set him back down with a novel object. This was repeated over and over to secure five minute periods without crying, then ten minute periods, and finally there was the day Ryan went thirty minutes. Four or five months later Ryan was enjoying the morning and afternoon as other infants were able to do.

Thumb-sucking. Thumb-sucking may be providing physiological and psychological comfort for your infant. The concern is a sucking of intensity and so sustained that it deforms the thumb, prevents normal mouthing activities with other objects, limits babbling, and creates dental problems.

Increasing aversive parental attention to the child's thumb-sucking also increases the frequency. Supplying an alternative such as a pacifier may or may not satisfy the infant's sucking needs and may or may not be a more easily eliminated behavior. The most important consideration is meeting the child's needs for security and good nutrition. Provide ample holding, touching, and rocking of baby. Give baby a variety of textures to suck and chew, i.e., crackers, zweibach, and popcicles made of pure juice. Check the nipple. An enlarged nipple opening may be releasing the liquid so easily that the sucking is not satisfying.

Optimally, thumb-sucking should be eliminated before the child is four years old. Most children seem to become so involved in play during their third year that a problem does not exist. When the thumb-sucking reaches a dentally-damaging or deforming thumb stage talk to both your doctor and your dentist.

Eating Habits. A newborn generally establishes a distincitvely individual feeding schedule. Problems arise with babies who spit-up following feedings. Frequently this occurs on the lovely new outfit of a visiting friend or on the expensive sofa that was finally paid for just before baby was born. Spitting-up formula is to be expected throughout the first four months. Prepare for it with cloth in hand and with a bib on the baby. Give the guest adequate warning before turning your precious baby over to the unexpecting anxious arms of an admiring guest.

In learning to eat solid food a baby has to learn to roll the food in with the tongue and then to swallow. This is a very different skill from nursing. Start with sips of formula, water,

and vegetables from a spoon. Allow baby to use hands with finger foods and help him learn to get the spoon to his mouth. Mastering the task of setting the cup on the table requires many spills. Mastering the table utensils comes slowly. When eating out in restaurants order simple finger foods for the infant or toddler. Learning to eat is part of baby's work. Just as many adults follow many jobs with a quick shower, babies clean up nicely, too.

Rigid schedules appear to increase the child's passion of consumption when food is finally made available. This rapid gulping occurs in short time and consequently more food is required than would have normally satisfied the hunger. More air is taken in with the gulping and causes later distress. Smaller amounts served more frequently during the day could make a happier day for parent and child. Children forced to eat all that has been placed on their plate are generally the "heavies" in teen years.

Try to include your older infant at the family meal time. Provide children a good model by trying some of every dish yourself. Know what the child's dietery needs for the day are in order to provide no more than the child really needs during the day. Meal time is a social event for a family and should be a pleasant time for all family members.

An up-tight attitude associated with meals leads to a no-win power struggle. Children have the tenacity to cry until fed; vomit if force-fed; refuse feedings; and make food on their trays into finger paint montages. Neither good nutritional attitudes nor habits will have been taught or caught.

Going To Bed. Infants have individual schedules for sleeping during the first months. Various physiological, sociological, and medicinal factors affect the infant's preparedness for liberation from the womb. Some babies experience stress that conflicts with the sleeping and social needs of the parents. Additionally babies

have an innate need to be a part of the total rhythm of the home. Where the parents have developed a fairly consistent and routine flow of activity and quiet, babies eventually mold with the tempo.

Unfortunately today there is so much that can be done at any hour and so much freedom for taking the baby wherever one needs to go that few households can really map out a dependable profile of a regular week. Consequently, babies develop a need to be with the parent until all have settled in the evening. A genuine desire to see the infant or toddler on a regular sleeping pattern dictates an attempt to provide stability and predictability in the child's routine. An entire sequence of events to occur regularly before the final tuck into bed both helps to develop the child's sense of trust, and helps to build an intuitive definition of time.

Tucking your child into bed at night caps the child's day with a sense of having been a needed and valuable part of the parents' life that day. A slow-paced ritual for completing the day's relationships becomes a storage for emotional pluses to be drawn against even throughout late adolescence. This is one part of your day with the child that should not be shortchanged for the sake of either child or parent.

Some infants and toddlers desire the companionship of their parents so much that they arouse for play during the middle of the night. In my opinion, if the parents are both working parents, they need to accept the non-traditional hours and supply the child's need.

Biting. As the infant and toddler cut teeth they exhibit a real need to mouth, chew, and bite. The potential of infection from the human bite as well as the horror expressed by other adults toward the offending biter combine to make a biting incidence a fretful ordeal. To punish by spanking, by scolding, or by biting the child back negatively reinforces the tendency

to bite. Massaging the gums; providing carrot and celery sticks, zweiback, popcicles to chew; and giving the infant-toddler the necessary cuddling needed all help to reduce the child's biting occassions.

A parent or adult must respond quickly when they realize that a child is moving into a biting phase. Successful efforts to get the child's own hand or finger in the mouth when the bite has been begun generally eliminates biting. Persistence usually succeeds in the child's getting a good bite into their own arm within the first week after biting begins. The bite has rarely been known to break the skin when self-inflicted. The pain however says a million words and is far more effective than other known practices.

Negativism. "No" becomes a repeated monologue between 13-18 months for all children. Undoubtedly every child has heard a succession of "no's" in their first eighteen months. Additionally, "no" reaps a decidedly different effect from parent than does compliance. It is my opinion that "No" allows the child time and space to process parental requests. I find that it takes very little redirection of the child to secure the required behavior. "No" separates the child as a person from the parent and strengthens the child's sense of self. Weeks of practice with "no" is followed by a higher level of negative logic, i.e., "dog not a cow." Punishment for use of "No" is rarely warranted.

Temper-Tantrums. Negativism often leads into a period of temper tantrums: banging the head on the floor, kicking at furniture or adults, and throwing objects. The abusing, destructive, or attacking toddler needs to be physically encircled by the parent's body and refrained from destructive behavior. When calmed, redirect the toddler to activities that release frustration. Play dough, fingerpainting, water play, pounding, music, swinging, and rocking are all tension and stress releasing.

Potty Training. "No" and temper tantrums often are simultaneously occurring with the beginning of potty training. Potty training needs to be preceded by the indication of wet pants by the child, by increased bladder control, and by the language that tells the parent of the need.

All adults around the child should use the same labels for potty training. Both the child-sized potty chair and the snap-on are available in a variety of models. The snap-on allows the child to imitate the parent on the parents' seat. Whichever seat is chosen, bowel and bladder control are major accomplishments in the child's life. Immediate mastery is not assurred. The mind set for adults in the toddler's home should be: We didn't mind changing dirty diapers, now we don't mind changing soiled training pants. Once a commitment is made to master bowel and bladder control, the child should be given the necessary positive support that will mean achievement.

Some positive actions by the parent include:

1) practicing the habit of changing the infant when wet;

2) having a set of books, fingerplays, and songs to read, act out, and sing with the child while on the potty seat;

3) supplying the child with an adequate number of training pants (9-12 pairs);

4) accepting warmly all efforts by the child while on the potty seat; and

5) changing soiled training pants as kindly as dirty diapers were changed.

Daytime control precedes night time control. Bladder control usually precedes bowel control. Checking liquid intake during the early evening may aid success. Be sensitive to the effect of changes in your schedule and a different environment on the child's control. Carry additional changes when you are going to be away from home. Cover the mattress with plastic. Do not call

attention to wet clothes or bed clothing. A reason to punish a child due to wet pants or dirty diapers has not been manufactured.

Alterations In Life-Style. Automatically expected behaviors are affected severly by divorce, death, illness, travel for vacations, guests, moving, arrival of a new sibling, and erratic schedules. Rarely does behavior escape the influence of any outward overt change. Sometimes the behavior warrants a physician's physical evaluation.

## Summary

In summary, infants and toddlers desire to please and seek recognition. They, too, enjoy being told what "I" would like them to do. Typically they welcome the adventure of change from the undesired to the more desirable behavior by a loving and physical contact such as two loving arms. The infant/toddler is easily diverted to new activities and surroundings. Repetition with language and gestures eventually lead to a healthy communication process between parents and toddlers.

BIBLIOGRAPHY

Buscaglia, L. Love. New York: Fawcett Books, 1972.

Campion, M. A. Especially for parents. Minneapolis: Bethany Fellowship, Inc., 1978.

Dobson, J. Dare to discipline. Wheaton, Illinois: Tyndale House Publishers, 1973.

Dodson, F. How to parent. New York: Signet, 1970.

Dreikurs, R. Coping with children's misbehaviors. New York: Hawthorn Books, Inc., 1972.

Freed, A. M. T.A. for tots and other prinzes. Sacramento: Jalmar Press, Inc., 1974.

Ginott, H. G. Between parent and child. New York: Avon, 1961.

Gordon, T. Parent effectiveness training. New York: New American Library, 1975.

Long, S. M., & Batchelor, B. (Eds.). When there is crisis: Helping children cope with change. Terre Haute, Indiana: Indiana Association for the Education of Young Children, 1979.

## APPENDIX A

## Sterilization of Bottles and Nipples

### Sterilizing and Preparing Baby's Bottles

Preparing baby's formula the right way is important. Formula must be made fresh every day and kept fresh, clean, and sterile.

Bacteria (germs) are everywhere and multiply very rapidly. Small babies can tolerate an amazing number of germs. However, too many of them can cause illness.

It is very important that all bottles, caps, nipples, and utensils used in preparing formula are sterilized. If you wish to avoid sterilizing bottles, caps, nipples, and utensils you may prefer to use the plastic nursers which come with sterile, disposable linings.

There are two methods of preparation and sterilization--the aseptic method and the terminal heating method.

### The Aseptic Method of Sterilization

The aseptic method of sterilization consists of sterilizing the bottles, nipples, caps, and all other equipment used to fill the baby's bottle. Sterilized formula (ready to use) is placed into sterilized bottles. To sterilize the bottles, caps, nipples, and equipment, follow the steps below.

1. Always wash hands thoroughly with hot, clean water and soap before preparing the baby's bottles.

2. Bottles, caps, nipples, and all equipment used in preparing the formula should be washed with hot, soapy water.

3. Rinse thoroughly with hot water. Water should be forced through each nipple to make certain that the holes are not clogged with formula from previous feedings.

4. Place nipples, caps, screw rings in a jar with a perforated lid.

5. Place all bottles, nipples, caps, rings, and all equipment used in formula preparation into the sterilizer or deep cooking utensil with a rack and lid. Pour in two inches of water. Bring to a boil.

6. Boil for five minutes. Do not remove lid while boiling.

7. Remove the sterilizer from the heat and let cool. When cool, remove lid and carefully lift out rack.

8. Remove bottles and equipment with tongs and place on a clean surface to drain. Place bottles upside down. Open jar which contains the nipples, caps, and rings on a clean surface to drain.

The Terminal Method of Sterilization

The terminal method consists of sterilization of the formula in the bottle. The following steps should be followed.

1. Wash hands thoroughly with hot, clean water and soap before preparing formula in the baby's bottle.

2. Wash all bottles, nipples, caps, and equipment with hot, soapy water. Rinse thoroughly with hot, running water and force water through holes in nipples.

3. Proceed with preparation of formula.

4. Wash and rinse top of can. Shake well and open with clean opener.

5. Measure prescribed formula mixture or evaporated milk plus sugar and add to the measured amount of water in mixing pitcher. Stir.

6. Pour number of ounces of mixed formula into each nursing bottle.

7. Cover opened can of formula or evaporated milk and refrigerate immediately. Use the entire contents of the opened can within 48 hours.

8. Place nipples and cap bottles loosely.

9. Place bottles in sterilizer or deep cooking utensil with rack and lid. Pour in three inches of water. Put lid on sterilizer and bring water to boil.

10. Boil gently for 25 minutes.

11. Remove sterilizer from heat and let cool.

12. Remove rack of bottles, tighten caps, and place bottles not to be used immediately in the refrigerator.

13. Bottled formula should be used within 24 hours.

Always remember to mix all formulas as instructed on the label or by your physician. Never make the formula more concentrated by adding extra powder or milk. Never dilute the formula by adding more water. Always measure and mix correctly so your baby will receive the proper formula.

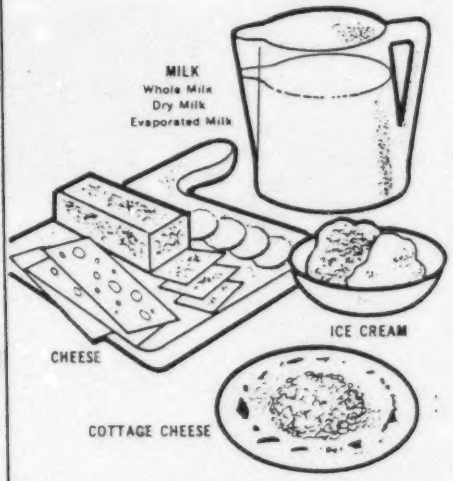
*DAILY GUIDE to good eating*

## MEAT GROUP

*2 or more servings daily*

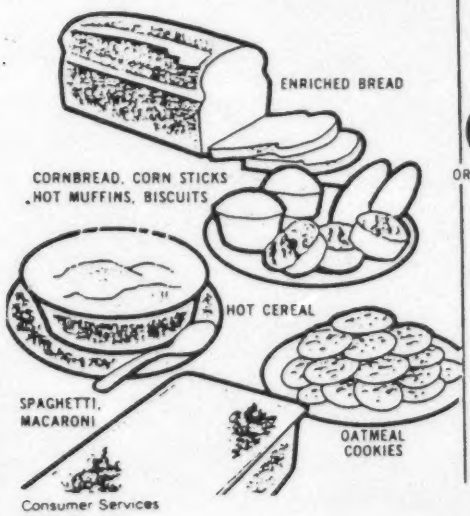
## MILK GROUP

*2 to 4 glasses*



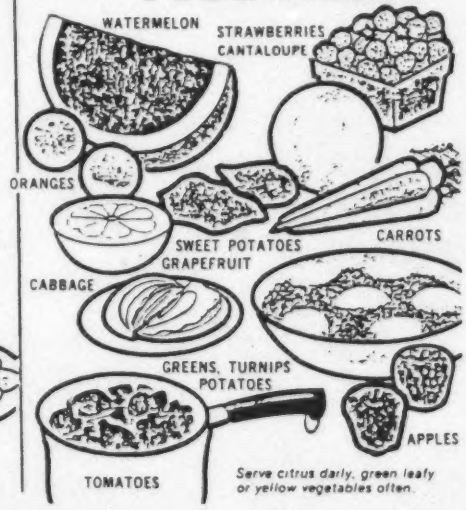

## CEREALS/BREADS

*4 servings daily*




## FRUITS/ VEGETABLES

*4 or more servings*




Consumer Services
Public Relations
Ralston Purina Co
Checkerboard Sq
Dept. 209
St. Louis, Mo. 63188

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Ralston Purina Company

## APPENDIX C

### Evaporated Formula

Formula prepared in the home from evaporated milk is less costly than commercial formulas. Evaporated milk is cow's milk which has had some water removed to one-half its original volume, sterilized and sealed in airtight containers.

Evaporated milk, because of the treatment to which it is subjected, is a uniform, easily digested food which has been used with excellent success in feeding infants. The heat treatment makes the milk less likely to cause allergy. Evaporated milk can be prepared for infant feeding simply by adding the prescribed amount of water and corn syrup.

### Evaporated Milk Formula

| | 1 & 2 months | 3 months | 4 months |
|---|---|---|---|
| Evaporated Milk | 9 oz. | 11 oz. | 13 oz. |
| Water | 24 oz. | 25 oz. | 26 oz. |
| Corn Syrup (Ex: Karo) | 2½ T. | 3 T. | 3½ T. |

When evaporated milk formula is selected for use, the following equipment is needed:

Standard measuring cup (quart preferably)
Measuring tablespoon (standard size)
Pitcher for mixing
Long-handled spoon

When evaporated milk is selected as the baby's formula, Vitmain C and fluoride supplementation is desirable. Begin an iron supplementation at 4 months of age.

APPENDIX D

Recipes and Things

1. Play Dough

1/4 cup salt

3/4 cup flour

4 tablespoons water
(add more as needed)

1 tablespoon oil

a few drops of
food coloring
(optional)

This dough lasts for weeks if you store it in the refrigerator in a plastic bag or covered jar. Children can pull and pound it, and then it can be collected and put away for another day, or they can make "things" and leave them to dry and harden. (Small children may put this dough in their mouths. It won't taste good, but it won't hurt them.) Let the child sit at the kitchen table or on the floor, using a cookie sheet for a working space. Dust his hands with a little flour so the dough won't stick to his fingers. He may just want to pound and squash it with his hands. Or he might have fun with:

a rolling pin, cookie cutters, spoons.

2. Finger Painting

Flour and Water Finger Paint: Mix flour and salt with a little water to make a paste the consistency of thick gravy. Sprinkle in a little food coloring. Use the formica counter top, a cookie sheet with raised sides on all four sides, or paper to paint on.

Shaving Cream Finger Paint: Non-mentholated shaving cream in a can can be used for finger painting. When soap begins to dry, a few drops of food coloring, water or more soap can be added. Keep a wet cloth handy to wipe the face if child gets soap near the eyes.

Soap-Flake Finger Paint: Mix a little water with soap flakes to make a paste. Add food coloring.

3. Try coloring, painting, or pasting on any of the following:

| | |
|---|---|
| shelf paper | foil |
| formica table top | cookie sheet |
| waxed paper | old boxes |
| paper plates | tissue paper |
| carbon paper | newspaper |
| large paper bags cut in half | brown wrapping paper |
| | shirt cardboards |
| meat trays | egg cartons |

4. Tools With Which To Paint:

| | |
|---|---|
| Fingers | Brush |
| Hands | Sponge |
| Toes | Cotton Balls |
| Feet | Q-Tips |
| Toothbrush | Straws |
| String | Objects (keys, jar lids, etc.) |

5. Please do not use any recipe for an art activity with infant and toddlers that requires cooking. The heat is retained too long in most recipes and could cause unnecessary burn.

## APPENDIX E

### Finger Plays and Songs

1. This Little Pig
2. Pat-a-Cake
3. Ride-a-Cock Horse
4. Twinkle, Twinkle Little Star
5. Rock-a-Bye Baby
6. Jesus Loves Me
7. Pease Porridge Hot

Finger plays and songs give another warm, productive meaning to the holding, touching, and rocking times that parents and babies spend together. Additionally, the receptive and expressive language that is developed from the repetition is very important in the development of preacademic skills.

The finger plays and songs suggested here are sequential in that they move from "This Little Pig" which is strictly parent play with the infant's toes to "Twinkle, Twinkle Little Star" which is imitative for infant to "Pease Porridge Hot" which is interactive for infant and parent.

Because of copyright restrictions, only titles have been listed. The simple and favorite finger plays listed can be found in most collections. Childcraft, a World Book Encyclopedia publication can be most enriching to any beginning family with a newborn.

## APPENDIX F

### Making the Baby Book Meaningful

Keeping a record for the development of each child in a family is important. Having the information recorded will reduce guessing the date at which baby mastered certain skills on entry to school or in case of serious injury. Having the record available when your infant has an assignment that requires biographical information reassures the child of his importance in the family as well as contributes to a better paper.

The records of childhood often can reaffirm that baby is developing in a predictable manner. The categories provided will vary in the number of statements recorded but each category is important. Though any program providing care for infants, toddlers, or preschoolers will maintain some records, keeping one's own notations is imperative.

A loose leaf two- or three-ring binder can allow for additional pages, pictures, and other important documents to be added during the exciting infant/toddler and preschool years. The personalized compilation of baby's records needs to be systematic. Schedule time for entries.

The areas suggested on the following pages if maintained will help plan for your child's needs as well as make you more sensitive to difficulties in the developmental stages. Be careful to date entry by month and year specifically.

David Eggert

CHILD'S NAME

| SMALL MOTOR SKILLS (includes rhythmic patterns and responses, use of various creative/manipulative media) | LARGE MOTOR SKILLS | CLASSIFICATION SKILLS (Separates according to how alike, how different) | LANGUAGE DEVELOPMENT AND VERBAL SKILLS (includes vocal music) | SOCIAL INTERACTION WITH OTHER CHILDREN |
|---|---|---|---|---|
| 3/79 - writes with large roll paint bottles: circular patterns, lines used water paint brush, crayons<br><br>4/79 - walks 2-3 inch beam with assistance for 4-6 inch beam<br><br>5/79 - walks long distances without tiring i.e. rabbit hutch, garden, bridge handles for, spoon, pulls off clothes at naptime; coat, shoes, socks<br><br>Digs, pushes toys in dirt hammers nails already in logs, opens doors | 6/79 - alternates feet climbing stairs without using hands now, also carries objects up & down stairs. Rides roll horse, inch worm, tractor which requires feet. Can ride forwards & backwards; same with hot wheels trucks;<br><br>Puzzles -<br><br>3, 4, 5, 7 piece<br><br>5/8 dowel through 7/8 hole<br><br>plays in finger paint, shaving cream, sand liquid starch | 3/79 - esp. sensitive to temperatures; cold; what belongs inside-outside<br><br>4/79 - loves attribute blocks; separates by shape, color, size, puts lids with size of bottle. | 3/79 - repeats and practices parts and phrases of almost anything said to him;<br><br>questions with commands or statements - often bodily asks for info<br><br>practices talking i.e. to toys in bed, in play<br><br>makes sounds of toys, trains, motors, animals<br><br>asks: what's this?<br>more milk?<br><br>uses puppets to talk with; hears sirens, train whistle, dump truck going by; listens to records, songs, does motions, folds hands at prayer<br><br>rote counting 1,2,3 when playing. | 3/79 - lots of smiling<br><br>enjoys playing by self but beside other children.<br><br>4/79 - shares yet stands for self.<br><br>likes animals kind<br><br>helps put toys away<br><br>enjoys small table games with adults and others<br><br>waits turn calls c. by name |

| RELATIONSHIP WITH PARENTS | RELATIONSHIP WITH OTHER ADULTS | PROBLEM-SOLVING SKILLS | INTELLECTUAL CURIOSITY (Exploratory Skills) | REPRESENTATIONAL SKILLS |
|---|---|---|---|---|
| 3/79 - likes Mother to interact w/materials w/him<br><br>always smiles when Daddy drives in.<br><br>reluctant to have either parent depart in a.m. for work - expects explanations | 4/79 - tells us when he wants drink, food, potty.<br><br>shows sense of humor to jokes, etc.; enjoys cooking, holding mixer spreading icing, shaking cheese<br><br>6/79 - esp. enjoys having someone lay down with him for naps. | 3/79 - Seeks help by getting person by hand, whining, withdraws. | 3/79 - "What's that" pokes, pushes, pulls, shakes, turns, rubs, observes; tests in everyway possible. | 4/79<br>A. language<br>1. sounds for transportation<br>2. animal sounds<br><br>B. Home<br>1. go home<br><br>C. knows nap comes after lunch |

APPENDIX G

Books for Baby and Parents

1. Books for baby and parents together:

   a. Wordless books with large clear pictures that resemble real objects, animals, and people.

   b. Childcraft How and Why Library, Volume 1, World Book Encyclopedia, Chicago, Illinois.

   c. Coonrod, Debbie and Valenti, Peggy, Child Development Through Musical Activity, Debcon, Incorporated, 1981.

   d. Coonrod, Debbie and Overman, Frances, Finger Play for Baby, Debcon Incorporated, 1982.

   e. Matterson, Elizabeth, Games for the Very Young, American Heritage Press, 1971.

   f. Sheehy, Emma Dickson, Children Discover Music and Dance, Ronald Press, 1970.

   g. Scarrys, Richard, Best World Book Ever, Golden Press, 1974.

2. Books for parents:

   a. Arnstein, Helene S., The Roots of Love, New York: Bobbs-Merrill Co., 1975.

   b. Brazelton, T. Berry, Infants and Mothers, New York: Delacorte Press, 1970.

c. Dodson, Fitzhugh, How to Parent, New York: The New American Library, 1970.

d. Fraiberg, Selma H., The Magic Years, New York: Charles Scribner's Sons, 1959.

e. Gordon, Ira J. Baby Learning Through Baby Play: A Parent's Guide for the First Two Years, New York: St. Martin's Press, 1972.

f. Gordon, Ira J. Child Learning Through Child Play: Learning Activities for Two and Three Year Olds, New York: St. Martin's Press, 1972.

g. Green, Martin I. ed.; A Sigh of Relief, The First Aid Handbook for Childhood Emergencies, New York: Bantom Books, 1977.

h. White, Burton L., The First Three Years of Life, Englewood Cliffs, N.J.: Prentice Hall, 1975.

APPENDIX H

Medications and Medical Equipment
for the Home

Fever -
- rectal thermometer
- vaseline or other similar lubricant
- tylenol (acetaminophen)

Colic -
- hot water bottle or heating pad

Colds (upper respiratory infection) -
- cool mist vaporizer
- salt water nosedrops (1/4 t/ in 8 oz. sterile water)

Diaper rash -
- 40 watt bulb
- cornstarch

Scabies and heat rash -
- calamine lotion

Ringworm -
- tinactin

Poisoning -
- Syrup of Ipecac - for medications and plants
- Milk of Magnesia - for acids, alkalines, and petroleum products

Cuts, abrasions, puncture wounds -
- hydrogen peroxide (3%)
- antibiotic ointment
- bandaids, butterfly closures, gauze

Medication aids -
- 10 cc. syringe without needle (ask your doctor)
- medication spoon (at drugstore)

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_____ HEALTH RECORD

| DATE | AGE | WT. | HT. | IMMUNIZATION | FOODS TO ADD | MISC. | ILLNESS | MEDS. | HEALTH CARE PROVIDER | COST |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |
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| | | | | | | | | | | |

# Picture of Mommy and Daddy

**Mommy - blue**

**Daddy - green**

Debcon, Incorporated
4503 North Northwoods Lane
Bloomington, Indiana 47401

**Sara**

**July 27, 19**